

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0120	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 8/16/2020 12:32 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 8/16/2020	Time: 12:32 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ 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. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ 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 01/01/2019 and ending 12/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	67,215	44,449	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	67,215	44,449	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 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/16/2020 12:32 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 600 SOUTH 13TH STREET			PO Box:				1.00	
2.00	City: PEKIN			State: IL		Zip Code: 61554		County: TAZEWELL	
		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
4.00	Subprovider - IPF							P	N
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2019	12/31/2019	
21.00	Type of Control (see instructions)						2		
							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		
22.01	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		
22.02	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		
22.03	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	
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		
				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	163	1	0	931	0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0120		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/16/2020 12:32 pm			
				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	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.							N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.							N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.							N	N	N	48.00
Teaching Hospitals											
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.							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 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.							N		60.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0120

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part I
Date/Time Prepared:
8/16/2020 12:32 pm

	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		
64.00 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. 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 01/01/2019
To 12/31/2019Worksheet S-2
Part I
Date/Time Prepared:
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	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		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
			1.00	2.00	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

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			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	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
					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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0120	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 8/16/2020 12:32 pm
		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
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
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		0115.00
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:	1,160,036	0	0118.01
		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	Removed and reserved			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 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/16/2020 12:32 pm	
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	
								1.00	
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.								146.00	
								1.00	
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	
				Part A		Part B		Title V	
				1.00		2.00		3.00	
								Title XIX	
								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	
156.00	Subprovider - IPF			N		N		N	
157.00	Subprovider - IRF			N		N		N	
158.00	SUBPROVIDER								
159.00	SNF			N		N		N	
160.00	HOME HEALTH AGENCY			N		N		N	
161.00	CMHC			N		N		N	
								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	
				Name		County		State	
				0		1.00		2.00	
								3.00	
								4.00	
								FTE/Campus	
								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	
								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	
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00	
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01	
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								0.00	
								Beginning	
								1.00	
								Ending	
								2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							170.00	
								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)							0	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0120	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 8/16/2020 12:32 pm
			Y/N 1.00	Date 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 1.00	Date 2.00	V/I 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 1.00	Type 2.00	Date 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 1.00	Legal Oper. 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 1.00	Date 2.00	Y/N 3.00
				Date 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		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	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		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		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0120

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part II
Date/Time Prepared:
8/16/2020 12:32 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		Y		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 8/16/2020 12:32 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/16/2020 12:32 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	87	34,671	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)		87	34,671	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)		95	37,591	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)		95			0	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 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/16/2020 12:32 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4,006	878	8,097			1.00
2.00	HMO and other (see instructions)	2,139	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)	4,006	878	8,097			7.00
8.00	INTENSIVE CARE UNIT	315	29	663			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		188	291			13.00
14.00	Total (see instructions)	4,321	1,095	9,051	0.00	278.40	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	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	278.40	27.00
28.00	Observation Bed Days		385	1,762			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			12			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	198	350			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 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/16/2020 12:32 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	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	1,050	299	2,137	1.00
2.00 HMO and other (see instructions)			435	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	1,050	299	2,137	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 01/01/2019
To 12/31/2019Worksheet S-3
Part II
Date/Time Prepared:
8/16/2020 12:32 pm

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	15,110,342	0	15,110,342	570,756.00	26.47
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		5,423	165,330	170,753	10,551.00	16.18
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,471,118	0	1,471,118	38,721.00	37.99
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		4,229,940	0	4,229,940	122,547.00	34.52
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		6,557,485	0	6,557,485		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		4,550	0	4,550		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0120

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part II
Date/Time Prepared:
8/16/2020 12:32 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on 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	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	77,036	0	77,036	2,278.00	33.82	26.00
27.00	Administrative & General	5.00	162,954	0	162,954	4,820.00	33.81	27.00
28.00	Administrative & General under contract (see inst.)		224,014	0	224,014	871.00	257.19	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	536,668	0	536,668	22,696.00	23.65	30.00
31.00	Laundry & Linen Service	8.00	30,825	0	30,825	2,202.00	14.00	31.00
32.00	Housekeeping	9.00	610,121	0	610,121	43,055.00	14.17	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	692,207	-583,951	108,256	6,614.00	16.37	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	418,621	418,621	25,571.00	16.37	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	103,535	0	103,535	3,220.00	32.15	38.00
39.00	Central Services and Supply	14.00	319,507	0	319,507	17,853.00	17.90	39.00
40.00	Pharmacy	15.00	771,890	0	771,890	18,850.00	40.95	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 01/01/2019
To 12/31/2019Worksheet S-3
Part III
Date/Time Prepared:
8/16/2020 12:32 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on 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)	15,334,356	0	15,334,356	571,627.00	26.83	1.00
2.00	Excluded area salaries (see instructions)	5,423	165,330	170,753	10,551.00	16.18	2.00
3.00	Subtotal salaries (line 1 minus line 2)	15,328,933	-165,330	15,163,603	561,076.00	27.03	3.00
4.00	Subtotal other wages & related costs (see inst.)	5,701,058	0	5,701,058	161,268.00	35.35	4.00
5.00	Subtotal wage-related costs (see inst.)	6,557,485	0	6,557,485	0.00	43.24	5.00
6.00	Total (sum of lines 3 thru 5)	27,587,476	-165,330	27,422,146	722,344.00	37.96	6.00
7.00	Total overhead cost (see instructions)	3,528,757	-165,330	3,363,427	148,030.00	22.72	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0120	Period: From 01/01/2019 To 12/31/2019	Worksheet S-3 Part IV Date/Time Prepared: 8/16/2020 12:32 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		816,888	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)		3,241,394	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)		1,502,913	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		9,549	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)		127,648	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		-24,246	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		1,118,846	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		2,553	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		26,594	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		6,822,139	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0120

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part V
Date/Time Prepared:
8/16/2020 12:32 pm

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0120

Period:
From 01/01/2019
To 12/31/2019

Worksheet S-10

Date/Time Prepared:
8/16/2020 12:32 pm

				1.00	
	Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.145862	1.00
	Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			4,956,956	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			66,256,974	6.00
7.00	Medicaid cost (line 1 times line 6)			9,664,375	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)			4,707,419	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)			4,707,419	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,101,651	573,977	1,675,628	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	160,689	573,977	734,666	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	160,689	573,977	734,666	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)			5,174,702	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			176,235	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			271,132	27.01
28.00	Non-Medicare bad debt expense (see instructions)			4,903,570	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			810,142	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			1,544,808	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			6,252,227	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 14-0120	Period: From 01/01/2019 To 12/31/2019	Worksheet A Date/Time Prepared: 8/16/2020 12:32 pm	
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (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	-216,328	-216,328	536,182	319,854	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	57,042	57,042	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	77,036	2,569	79,605	79,605	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	162,954	5,350,317	5,513,271	-76,071	5.00
7.00	00700	OPERATION OF PLANT	536,668	2,365,707	2,902,375	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	30,825	37,621	68,446	68,446	8.00
9.00	00900	HOUSEKEEPING	610,121	429,696	1,039,817	0	9.00
10.00	01000	DIETARY	692,207	471,584	1,163,791	-981,782	10.00
11.00	01100	CAFETERIA	0	0	703,816	703,816	11.00
13.00	01300	NURSING ADMINISTRATION	103,535	22,011	125,546	125,546	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	319,507	158,454	477,961	-23,657	14.00
15.00	01500	PHARMACY	771,890	1,607,152	2,379,042	-1,279,683	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,260,252	2,066,953	5,327,205	-1,657,709	30.00
31.00	03100	INTENSIVE CARE UNIT	623,849	195,299	819,148	-48,431	31.00
43.00	04300	NURSERY	0	0	88,828	88,828	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,965,243	4,015,679	5,980,922	-2,534,886	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	372,964	372,964	52.00
53.00	05300	ANESTHESIOLOGY	0	103,115	103,115	-112,571	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,234,232	521,687	1,755,919	109,564	54.00
56.00	05600	RADIOISOTOPE	149,669	213,943	363,612	-363,612	56.00
57.00	05700	CT SCAN	346,458	329,550	676,008	-95,587	57.00
58.00	05800	MRI	144,024	331,691	475,715	-18,963	58.00
59.00	05900	CARDIAC CATHETERIZATION	122,938	270,912	393,850	-215,502	59.00
60.00	06000	LABORATORY	724,992	1,383,712	2,108,704	-233,962	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	151,999	151,999	63.00
64.00	06400	INTRAVENOUS THERAPY	92,055	16,902	108,957	1,160,390	64.00
65.00	06500	RESPIRATORY THERAPY	428,387	185,606	613,993	3,027	65.00
66.00	06600	PHYSICAL THERAPY	0	604,640	604,640	-181,920	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	44,079	44,079	98,749	67.00
68.00	06800	SPEECH PATHOLOGY	0	41,019	41,019	96,979	68.00
69.00	06900	ELECTROCARDIOLOGY	211,166	318,002	529,168	-236,909	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	55,633	55,633	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	2,638,621	2,638,621	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,888,337	1,888,337	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,498,670	1,498,670	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03610	SLEEP LAB	111,850	380,785	492,635	-434,065	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	385,916	240,657	626,573	177,787	90.00
91.00	09100	EMERGENCY	1,999,145	1,964,181	3,963,326	-904,091	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		727,655	727,655	-517,153	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,104,919	24,184,850	39,289,769	-277,966	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,423	9,387	14,810	277,966	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		TOTAL (SUM OF LINES 118 through 199)	15,110,342	24,194,237	39,304,579	0	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0120

Period:
From 01/01/2019
To 12/31/2019

Worksheet A

Date/Time Prepared:
8/16/2020 12:32 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	319,854	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	57,042	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-434,755	-355,150	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,607,396	12,044,596	5.00
7.00	00700	OPERATION OF PLANT	296,424	3,198,799	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,380	71,826	8.00
9.00	00900	HOUSEKEEPING	-19,644	1,020,173	9.00
10.00	01000	DIETARY	3,401	185,410	10.00
11.00	01100	CAFETERIA	-315,016	388,800	11.00
13.00	01300	NURSING ADMINISTRATION	915,275	1,040,821	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,558	457,862	14.00
15.00	01500	PHARMACY	9,024	1,108,383	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	339,748	339,748	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,293	3,671,789	30.00
31.00	03100	INTENSIVE CARE UNIT	47,085	817,802	31.00
43.00	04300	NURSERY	0	88,828	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	30,783	3,476,819	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	372,964	52.00
53.00	05300	ANESTHESIOLOGY	9,456	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	145,553	2,011,036	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	63,044	643,465	57.00
58.00	05800	MRI	0	456,752	58.00
59.00	05900	CARDIAC CATHETERIZATION	40,570	218,918	59.00
60.00	06000	LABORATORY	-51,351	1,823,391	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	151,999	63.00
64.00	06400	INTRAVENOUS THERAPY	0	1,269,347	64.00
65.00	06500	RESPIRATORY THERAPY	0	617,020	65.00
66.00	06600	PHYSICAL THERAPY	0	422,720	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	142,828	67.00
68.00	06800	SPEECH PATHOLOGY	0	137,998	68.00
69.00	06900	ELECTROCARDIOLOGY	3,315	295,574	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	55,633	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,638,621	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,888,337	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,498,670	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03610	SLEEP LAB	0	58,570	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-116,306	688,054	90.00
91.00	09100	EMERGENCY	-765,319	2,293,916	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-210,502	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,607,412	45,619,215	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	292,776	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)	6,607,412	45,911,991	200.00

RECLASSIFICATIONS

Provider CCN: 14-0120

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-6

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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - TO RECLASS CAFETERIA COSTS					
1.00	CAFETERIA	11.00	418,621	285,195		1.00
2.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	165,330	112,636		2.00
			583,951	397,831		
	E - TO RECLASS SUPPLY COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,638,621		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	2,638,621		
	F - TO RECLASS BILLABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,498,670		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
			0	1,498,670		
	G - IMPLANTIBLES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,888,337		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
			0	1,888,337		
	H - BLOOD					
1.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	151,999		1.00
	TOTALS		0	151,999		
	I - TO RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	517,153		1.00
			0	517,153		
	J - TO RECLASS PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	19,029		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	57,042		2.00
			0	76,071		

RECLASSIFICATIONS

Provider CCN: 14-0120

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-6

Date/Time Prepared:
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Increases					
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
K - COST CENTER MAPPING					
1.00	NURSERY	43.00	68,885	19,943	1.00
2.00	OPERATING ROOM	50.00	198,383	124,499	2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	289,228	83,736	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	163,807	70,039	4.00
5.00	CT SCAN	57.00	1,739	390	5.00
6.00	LABORATORY	60.00	3,098	569	6.00
7.00	INTRAVENOUS THERAPY	64.00	704,024	465,153	7.00
8.00	RESPIRATORY THERAPY	65.00	46,791	28,765	8.00
9.00	OCCUPATIONAL THERAPY	67.00	0	98,749	9.00
10.00	SPEECH PATHOLOGY	68.00	11,110	85,869	10.00
11.00	ELECTROENCEPHALOGRAPHY	70.00	31,109	24,524	11.00
12.00	CLINIC	90.00	105,746	105,583	12.00
0			1,623,920	1,107,819	
N - TO RECLASS ANESTHESIOLOGY EXPENSE					
1.00	OPERATING ROOM	50.00	0	27,161	1.00
0			0	27,161	
500.00	Grand Total: Increases		2,207,871	8,303,662	500.00

RECLASSIFICATIONS

Provider CCN: 14-0120

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-6

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	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	583,951	397,831	0		1.00
2.00		0.00	0	0	0		2.00
			583,951	397,831			
	E - TO RECLASS SUPPLY COSTS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	19,565	0		1.00
2.00	PHARMACY	15.00	0	17,364	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	317,802	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	385	0		4.00
5.00	OPERATING ROOM	50.00	0	1,174,862	0		5.00
6.00	ANESTHESIOLOGY	53.00	0	68,630	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	50,762	0		7.00
8.00	RADIOISOTOPE	56.00	0	166,538	0		8.00
9.00	CT SCAN	57.00	0	75,562	0		9.00
10.00	MRI	58.00	0	1,943	0		10.00
11.00	CARDIAC CATHETERIZATION	59.00	0	18,089	0		11.00
12.00	LABORATORY	60.00	0	81,187	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	68,440	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	519	0		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	231,494	0		15.00
16.00	SLEEP LAB	76.00	0	103,148	0		16.00
17.00	CLINIC	90.00	0	17,067	0		17.00
18.00	EMERGENCY	91.00	0	225,264	0		18.00
			0	2,638,621			
	F - TO RECLASS BILLABLE DRUGS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,166	0		1.00
2.00	PHARMACY	15.00	0	1,262,319	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	47,647	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	12	0		4.00
5.00	OPERATING ROOM	50.00	0	41,722	0		5.00
6.00	ANESTHESIOLOGY	53.00	0	14,140	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,252	0		7.00
8.00	RADIOISOTOPE	56.00	0	704	0		8.00
9.00	CT SCAN	57.00	0	19,159	0		9.00
10.00	MRI	58.00	0	15,604	0		10.00
11.00	CARDIAC CATHETERIZATION	59.00	0	8,500	0		11.00
12.00	LABORATORY	60.00	0	4,443	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	4,089	0		13.00
14.00	ELECTROCARDIOLOGY	69.00	0	408	0		14.00
15.00	SLEEP LAB	76.00	0	2,459	0		15.00
16.00	CLINIC	90.00	0	188	0		16.00
17.00	EMERGENCY	91.00	0	73,858	0		17.00
			0	1,498,670			
	G - IMPLANTIBLES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,926	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	14,465	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	185	0		3.00
4.00	OPERATING ROOM	50.00	0	1,668,345	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	2,640	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	42	0		6.00
7.00	RADIOISOTOPE	56.00	0	835	0		7.00
8.00	CT SCAN	57.00	0	2,995	0		8.00
9.00	MRI	58.00	0	1,416	0		9.00
10.00	CARDIAC CATHETERIZATION	59.00	0	34,123	0		10.00
11.00	ELECTROCARDIOLOGY	69.00	0	654	0		11.00
12.00	SLEEP LAB	76.00	0	123,536	0		12.00
13.00	CLINIC	90.00	0	3	0		13.00
14.00	EMERGENCY	91.00	0	36,172	0		14.00
			0	1,888,337			
	H - BLOOD						
1.00	LABORATORY	60.00	0	151,999	0		1.00
	TOTALS		0	151,999			
	I - TO RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	517,153	11		1.00
			0	517,153			
	J - TO RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	76,071	12		1.00
2.00		0.00	0	0	12		2.00
			0	76,071			
	K - COST CENTER MAPPING						
1.00	ADULTS & PEDIATRICS	30.00	906,073	371,722	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	36,467	11,382	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	52,613	18,613	0		3.00
4.00	RADIOISOTOPE	56.00	149,669	45,866	0		4.00

RECLASSIFICATIONS

Provider CCN: 14-0120

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-6

Date/Time Prepared:
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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	57,122	97,668	0	5.00
6.00	INTRAVENOUS THERAPY	64.00	7,424	1,363	0	6.00
7.00	PHYSICAL THERAPY	66.00	0	181,401	0	7.00
8.00	ELECTROCARDIOLOGY	69.00	3,099	1,254	0	8.00
9.00	SLEEP LAB	76.00	88,710	116,212	0	9.00
10.00	CLINIC	90.00	9,320	6,964	0	10.00
11.00	EMERGENCY	91.00	313,423	255,374	0	11.00
12.00		0.00	0	0	0	12.00
	0		1,623,920	1,107,819		
N - TO RECLASS ANESTHESIOLOGY EXPENSE						
1.00	ANESTHESIOLOGY	53.00	0	27,161	0	1.00
	0		0	27,161		
500.00	Grand Total: Decreases		2,207,871	8,303,662		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0120

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part I
Date/Time Prepared:
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		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	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	21,296,567	2,972,167	0	2,972,167	0	4.00
5.00	Fixed Equipment	20,016,540	103,199	0	103,199	0	5.00
6.00	Movable Equipment	34,926,203	1,163,881	0	1,163,881	1,359,599	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	92,032,127	4,239,247	0	4,239,247	1,359,599	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	92,032,127	4,239,247	0	4,239,247	1,359,599	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	24,268,734	0				4.00
5.00	Fixed Equipment	20,119,739	0				5.00
6.00	Movable Equipment	34,730,485	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	94,911,775	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	94,911,775	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0120

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part II
Date/Time Prepared:
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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	-216,328	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)	-216,328	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	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	-216,328				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	-216,328				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0120

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part III
Date/Time Prepared:
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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	60,181,290	0	60,181,290	0.634076	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	34,730,485	0	34,730,485	0.365924	0	2.00
3.00	Total (sum of lines 1-2)	94,911,775	0	94,911,775	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	-216,328	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	-216,328	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	517,153	19,029	0	0	319,854	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	57,042	0	0	57,042	2.00
3.00	Total (sum of lines 1-2)	517,153	76,071	0	0	376,896	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0120

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-8

Date/Time Prepared:
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Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP 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	-1,138,929			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	8,184,108			0	12.00
13.00	Laundry and linen service	B		0HOUSEKEEPING	9.00	0	13.00
14.00	Cafeteria-employees and guests	B		0CAFETERIA	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		0MEDICAL 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		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL 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			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP 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		0OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH 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	-315,016	CAFETERIA	11.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0120

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-8

Date/Time Prepared:
8/16/2020 12:32 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.01	MISCELLANEOUS REVENUE	B	95	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	MISCELLANEOUS REVENUE	B	-19,644	HOUSEKEEPING	9.00	0	33.02
33.03	MISCELLANEOUS REVENUE	B	0	NURSING ADMINISTRATION	13.00	0	33.03
33.04	MISCELLANEOUS REVENUE	B	-90	ADULTS & PEDIATRICS	30.00	0	33.04
33.05	MISCELLANEOUS REVENUE	B	-186	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	-177	ANESTHESIOLOGY	53.00	0	33.14
33.15	SELF INSURANCE EXPENSE	A	-712,533	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.15
33.16	REMOVE NON-ALLOWABLE INTEREST	A	-138,425	INTEREST EXPENSE	113.00	0	33.16
33.17	DEPRECIATION TO AHA	A	180,341	OPERATION OF PLANT	7.00	0	33.17
33.18	DEPRECIATION TO AHA	A	3,380	LAUNDRY & LINEN SERVICE	8.00	0	33.18
33.19	DEPRECIATION TO AHA	A	3,401	DIETARY	10.00	0	33.19
33.20	DEPRECIATION TO AHA	A	3,558	CENTRAL SERVICES & SUPPLY	14.00	0	33.20
33.21	DEPRECIATION TO AHA	A	9,024	PHARMACY	15.00	0	33.21
33.22	DEPRECIATION TO AHA	A	2,383	ADULTS & PEDIATRICS	30.00	0	33.22
33.23	DEPRECIATION TO AHA	A	47,085	INTENSIVE CARE UNIT	31.00	0	33.23
33.24	DEPRECIATION TO AHA	A	167,658	OPERATING ROOM	50.00	0	33.24
33.25	DEPRECIATION TO AHA	A	9,633	ANESTHESIOLOGY	53.00	0	33.25
33.26	DEPRECIATION TO AHA	A	145,739	RADIOLOGY-DIAGNOSTIC	54.00	0	33.26
33.27	DEPRECIATION TO AHA	A	63,044	CT SCAN	57.00	0	33.27
33.28	DEPRECIATION TO AHA	A	40,570	CARDIAC CATHETERIZATION	59.00	0	33.28
33.29	DEPRECIATION TO AHA	A	16,149	LABORATORY	60.00	0	33.29
33.30	DEPRECIATION TO AHA	A	3,315	ELECTROCARDIOLOGY	69.00	0	33.30
33.31	DEPRECIATION TO AHA	A	52,929	EMERGENCY	91.00	0	33.31
33.32	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.32
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		6,607,412				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 01/01/2019
To 12/31/2019

Worksheet A-8-1

Date/Time Prepared:
8/16/2020 12:32 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	PEORIA HOME OFFICE	277,683	0	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	PEORIA HOME OFFICE	339,748	0	2.00
3.00	13.00	NURSING ADMINISTRATION	PEORIA HOME OFFICE	915,275	0	3.00
4.00	7.00	OPERATION OF PLANT	PEORIA HOME OFFICE	116,083	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	PEORIA HOME OFFICE	6,607,396	0	4.01
4.02	113.00	INTEREST EXPENSE	PEORIA HOME OFFICE	614,574	686,651	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			8,870,759	686,651	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.

	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 01/01/2019
To 12/31/2019

Worksheet A-8-1

Date/Time Prepared:
8/16/2020 12:32 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	277,683	9		1.00
2.00	339,748	0		2.00
3.00	915,275	0		3.00
4.00	116,083	0		4.00
4.01	6,607,396	0		4.01
4.02	-72,077	0		4.02
5.00	8,184,108			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 01/01/2019
To 12/31/2019

Worksheet A-8-2

Date/Time Prepared:
8/16/2020 12:32 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	OPERATING ROOM	136,875	136,875	0	0	0	1.00
2.00	60.00	LABORATORY	67,500	67,500	0	0	0	2.00
3.00	90.00	CLINIC	120,068	113,408	6,660	211,500	37	3.00
4.00	91.00	EMERGENCY	818,248	818,248	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			1,142,691	1,136,031	6,660		37	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	3,762	188	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			3,762	188	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	136,875		1.00
2.00	60.00	LABORATORY	0	0	0	67,500		2.00
3.00	90.00	CLINIC	0	3,762	2,898	116,306		3.00
4.00	91.00	EMERGENCY	0	0	0	818,248		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	3,762	2,898	1,138,929		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0120

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
8/16/2020 12:32 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	319,854	319,854			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	57,042		57,042		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-355,150	1,306	0	-353,844	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,044,596	107,190	272	0	5.00
7.00	00700	OPERATION OF PLANT	3,198,799	44,211	19,097	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	71,826	3,311	312	0	8.00
9.00	00900	HOUSEKEEPING	1,020,173	263	92	0	9.00
10.00	01000	DIETARY	185,410	6,304	0	0	10.00
11.00	01100	CAFETERIA	388,800	1,763	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,040,821	8,513	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	457,862	4,589	381	0	14.00
15.00	01500	PHARMACY	1,108,383	1,518	2,227	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	339,748	3,793	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,671,789	36,549	1,178	0	30.00
31.00	03100	INTENSIVE CARE UNIT	817,802	3,518	1,228	0	31.00
43.00	04300	NURSERY	88,828	914	57	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,476,819	18,386	10,728	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	372,964	2,224	240	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,011,036	14,586	4,896	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	643,465	680	3,433	0	57.00
58.00	05800	MRI	456,752	1,793	5,016	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	218,918	675	1,997	0	59.00
60.00	06000	LABORATORY	1,823,391	5,312	817	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	151,999	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	1,269,347	0	602	0	64.00
65.00	06500	RESPIRATORY THERAPY	617,020	1,347	441	0	65.00
66.00	06600	PHYSICAL THERAPY	422,720	3,486	41	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	142,828	424	12	0	67.00
68.00	06800	SPEECH PATHOLOGY	137,998	1,631	14	0	68.00
69.00	06900	ELECTROCARDIOLOGY	295,574	4,701	726	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	55,633	0	321	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,638,621	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,888,337	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,498,670	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03610	SLEEP LAB	58,570	653	22	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	688,054	1,784	606	0	90.00
91.00	09100	EMERGENCY	2,293,916	12,985	2,286	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	45,619,215	294,409	57,042	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	292,776	3,520	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	16,140	0	0	192.00
194.00	07950	VACANT SPACE	0	870	0	0	194.00
194.01	07951	LEASED SPACE	0	4,477	0	0	194.01
194.02	07952	FOUNDATION	0	438	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	-353,844	201.00
202.00		TOTAL (sum lines 118 through 201)	45,911,991	319,854	57,042	-353,844	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0120

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
8/16/2020 12:32 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,152,058					5.00
7.00	00700	OPERATION OF PLANT	1,162,031	4,424,138				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	26,877	87,647	189,973			8.00
9.00	00900	HOUSEKEEPING	363,534	6,961	0	1,391,023		9.00
10.00	01000	DIETARY	68,293	166,862	0	53,611	480,480	10.00
11.00	01100	CAFETERIA	139,127	46,674	0	14,996	0	11.00
13.00	01300	NURSING ADMINISTRATION	373,795	225,332	0	72,396	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	164,870	121,473	1,346	39,028	0	14.00
15.00	01500	PHARMACY	396,163	40,180	1,112	12,909	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	122,377	100,402	0	32,258	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,321,421	967,390	52,624	310,809	444,115	30.00
31.00	03100	INTENSIVE CARE UNIT	293,009	93,114	3,501	29,916	36,365	31.00
43.00	04300	NURSERY	31,988	24,201	835	7,776	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	1,248,887	486,639	44,697	156,351	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	133,735	58,868	3,504	18,913	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	723,313	386,074	27,349	124,041	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	230,681	17,987	0	5,779	0	57.00
58.00	05800	MRI	165,130	47,468	2,640	15,251	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	78,935	17,871	0	5,742	0	59.00
60.00	06000	LABORATORY	651,713	140,605	45	45,175	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	54,145	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	452,383	0	12,155	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	220,432	35,648	706	11,453	0	65.00
66.00	06600	PHYSICAL THERAPY	151,838	92,273	2,309	29,646	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	51,034	11,213	696	3,603	0	67.00
68.00	06800	SPEECH PATHOLOGY	49,744	43,170	414	13,870	0	68.00
69.00	06900	ELECTROCARDIOLOGY	107,223	124,416	0	39,973	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	19,932	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	939,932	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	672,665	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	533,858	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03610	SLEEP LAB	21,104	17,287	0	5,554	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	245,951	47,211	450	15,168	0	90.00
91.00	09100	EMERGENCY	822,581	343,698	35,590	110,426	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,038,701	3,750,664	189,973	1,174,644	480,480	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	105,547	93,160	0	29,931	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,749	427,188	0	137,250	0	192.00
194.00	07950	VACANT SPACE	310	23,033	0	7,400	0	194.00
194.01	07951	LEASED SPACE	1,595	118,506	0	38,075	0	194.01
194.02	07952	FOUNDATION	156	11,587	0	3,723	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)	12,152,058	4,424,138	189,973	1,391,023	480,480	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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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	591,360				11.00
13.00	01300	NURSING ADMINISTRATION	3,697	1,724,554			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	20,488	0	810,037		14.00
15.00	01500	PHARMACY	21,537	0	0	1,584,029	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	106,851	1,542,782	57,265	0	30.00
31.00	03100	INTENSIVE CARE UNIT	26,475	126,326	69	0	31.00
43.00	04300	NURSERY	2,290	55,446	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	86,746	0	186,448	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,612	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	53,164	0	21,417	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	13,309	0	30,045	0	57.00
58.00	05800	MRI	5,486	0	13,632	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,552	0	351	0	59.00
60.00	06000	LABORATORY	34,250	0	2,813	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	14,647	0	63.00
64.00	06400	INTRAVENOUS THERAPY	32,175	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	19,081	0	0	48,935	65.00
66.00	06600	PHYSICAL THERAPY	0	0	7,878	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	94	0	67.00
68.00	06800	SPEECH PATHOLOGY	358	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,181	0	41,763	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,097	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	30,618	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	340,670	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,584,029	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03610	SLEEP LAB	1,049	0	18,609	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	70,813	0	3,079	0	90.00
91.00	09100	EMERGENCY	59,985	0	40,639	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				22,665	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)	579,196	1,724,554	810,037	1,584,029	598,578
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,164	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	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	591,360	1,724,554	810,037	1,584,029	598,578

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,868,487	0	8,868,487	30.00
31.00	03100	INTENSIVE CARE UNIT	1,448,610	0	1,448,610	31.00
43.00	04300	NURSERY	238,379	0	238,379	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,843,634	0	5,843,634	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	600,060	0	600,060	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,365,876	0	3,365,876	54.00
56.00	05600	RADIOISOTOPE	0	0	0	56.00
57.00	05700	CT SCAN	945,379	0	945,379	57.00
58.00	05800	MRI	713,168	0	713,168	58.00
59.00	05900	CARDIAC CATHETERIZATION	327,041	0	327,041	59.00
60.00	06000	LABORATORY	2,704,121	0	2,704,121	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	220,791	0	220,791	63.00
64.00	06400	INTRAVENOUS THERAPY	1,766,662	0	1,766,662	64.00
65.00	06500	RESPIRATORY THERAPY	955,063	0	955,063	65.00
66.00	06600	PHYSICAL THERAPY	710,191	0	710,191	66.00
67.00	06700	OCCUPATIONAL THERAPY	209,904	0	209,904	67.00
68.00	06800	SPEECH PATHOLOGY	247,199	0	247,199	68.00
69.00	06900	ELECTROCARDIOLOGY	622,557	0	622,557	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	76,983	0	76,983	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,609,171	0	3,609,171	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,901,672	0	2,901,672	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,616,557	0	3,616,557	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
76.00	03610	SLEEP LAB	122,848	0	122,848	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,073,116	0	1,073,116	90.00
91.00	09100	EMERGENCY	3,744,771	0	3,744,771	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44,932,240	0	44,932,240	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	537,098	0	537,098	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	586,327	0	586,327	192.00
194.00	07950	VACANT SPACE	31,613	0	31,613	194.00
194.01	07951	LEASED SPACE	162,653	0	162,653	194.01
194.02	07952	FOUNDATION	15,904	0	15,904	194.02
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	-353,844	0	-353,844	201.00
202.00		TOTAL (sum lines 118 through 201)	45,911,991	0	45,911,991	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			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	-274,965	1,306	0	-273,659	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,037	107,190	272	122,499	5.00
7.00	00700	OPERATION OF PLANT	1,059,488	44,211	19,097	1,122,796	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,247	3,311	312	20,870	8.00
9.00	00900	HOUSEKEEPING	5,078	263	92	5,433	9.00
10.00	01000	DIETARY	0	6,304	0	6,304	10.00
11.00	01100	CAFETERIA	0	1,763	0	1,763	11.00
13.00	01300	NURSING ADMINISTRATION	0	8,513	0	8,513	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	110,395	4,589	381	115,365	14.00
15.00	01500	PHARMACY	156,211	1,518	2,227	159,956	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,793	0	3,793	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	65,133	36,549	1,178	102,860	30.00
31.00	03100	INTENSIVE CARE UNIT	67,919	3,518	1,228	72,665	31.00
43.00	04300	NURSERY	3,155	914	57	4,126	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	600,555	18,386	10,728	629,669	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,245	2,224	240	15,709	52.00
53.00	05300	ANESTHESIOLOGY	22,476	0	0	22,476	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	270,687	14,586	4,896	290,169	54.00
56.00	05600	RADIOISOTOPE	16	0	0	16	56.00
57.00	05700	CT SCAN	189,847	680	3,433	193,960	57.00
58.00	05800	MRI	277,332	1,793	5,016	284,141	58.00
59.00	05900	CARDIAC CATHETERIZATION	110,418	675	1,997	113,090	59.00
60.00	06000	LABORATORY	45,198	5,312	817	51,327	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	33,300	0	602	33,902	64.00
65.00	06500	RESPIRATORY THERAPY	24,398	1,347	441	26,186	65.00
66.00	06600	PHYSICAL THERAPY	4,975	3,486	41	8,502	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,500	424	12	1,936	67.00
68.00	06800	SPEECH PATHOLOGY	1,111	1,631	14	2,756	68.00
69.00	06900	ELECTROCARDIOLOGY	40,134	4,701	726	45,561	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	17,772	0	321	18,093	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03610	SLEEP LAB	1,242	653	22	1,917	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	34,997	1,784	606	37,387	90.00
91.00	09100	EMERGENCY	126,385	12,985	2,286	141,656	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,040,286	294,409	57,042	3,391,737	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,520	0	3,520	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	16,140	0	16,140	192.00
194.00	07950	VACANT SPACE	0	870	0	870	194.00
194.01	07951	LEASED SPACE	0	4,477	0	4,477	194.01
194.02	07952	FOUNDATION	0	438	0	438	194.02
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,040,286	319,854	57,042	3,417,182	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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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	122,499					5.00
7.00	00700	OPERATION OF PLANT	11,714	1,134,510				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	271	22,476	43,617			8.00
9.00	00900	HOUSEKEEPING	3,665	1,785	0	10,883		9.00
10.00	01000	DIETARY	688	42,789	0	419	50,200	10.00
11.00	01100	CAFETERIA	1,403	11,969	0	117	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,768	57,783	0	566	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,662	31,150	309	305	0	14.00
15.00	01500	PHARMACY	3,994	10,303	255	101	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,234	25,747	0	252	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,317	248,076	12,083	2,434	46,401	30.00
31.00	03100	INTENSIVE CARE UNIT	2,954	23,878	804	234	3,799	31.00
43.00	04300	NURSERY	322	6,206	192	61	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	12,590	124,792	10,262	1,223	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,348	15,096	805	148	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,292	99,003	6,279	970	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	2,325	4,613	0	45	0	57.00
58.00	05800	MRI	1,665	12,172	606	119	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	796	4,583	0	45	0	59.00
60.00	06000	LABORATORY	6,570	36,056	10	353	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	546	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	4,560	0	2,791	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,222	9,141	162	90	0	65.00
66.00	06600	PHYSICAL THERAPY	1,531	23,662	530	232	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	514	2,875	160	28	0	67.00
68.00	06800	SPEECH PATHOLOGY	501	11,070	95	109	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,081	31,905	0	313	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	201	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,475	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,781	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,382	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03610	SLEEP LAB	213	4,433	0	43	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,479	12,107	103	119	0	90.00
91.00	09100	EMERGENCY	8,292	88,137	8,171	864	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	121,356	961,807	43,617	9,190	50,200	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,064	23,890	0	234	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	58	109,546	0	1,074	0	192.00
194.00	07950	VACANT SPACE	3	5,907	0	58	0	194.00
194.01	07951	LEASED SPACE	16	30,389	0	298	0	194.01
194.02	07952	FOUNDATION	2	2,971	0	29	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)	122,499	1,134,510	43,617	10,883	50,200	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0120

Period:
From 01/01/2019
To 12/31/2019Worksheet B
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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	15,252					11.00
13.00	01300	NURSING ADMINISTRATION	95	70,725				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	528	0	149,319			14.00
15.00	01500	PHARMACY	555	0	0	175,164		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	31,026	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,759	63,270	10,556	0	18,438	30.00
31.00	03100	INTENSIVE CARE UNIT	683	5,181	13	0	896	31.00
43.00	04300	NURSERY	59	2,274	0	0	1,350	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,237	0	34,369	0	6,631	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	248	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,371	0	3,948	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	343	0	5,538	0	0	57.00
58.00	05800	MRI	141	0	2,513	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	66	0	65	0	0	59.00
60.00	06000	LABORATORY	883	0	518	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	2,700	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	830	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	492	0	0	0	2,536	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,452	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	17	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	9	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	211	0	7,699	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	28	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	5,644	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	62,798	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	175,164	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03610	SLEEP LAB	27	0	3,430	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,826	0	568	0	0	90.00
91.00	09100	EMERGENCY	1,547	0	7,491	0	1,175	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,938	70,725	149,319	175,164	31,026	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	314	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)	15,252	70,725	149,319	175,164	31,026	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0120

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
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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	520,194	0	520,194	30.00
31.00	03100	INTENSIVE CARE UNIT	111,107	0	111,107	31.00
43.00	04300	NURSERY	14,590	0	14,590	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	821,773	0	821,773	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	33,354	0	33,354	52.00
53.00	05300	ANESTHESIOLOGY	22,476	0	22,476	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	409,032	0	409,032	54.00
56.00	05600	RADIOISOTOPE	16	0	16	56.00
57.00	05700	CT SCAN	206,824	0	206,824	57.00
58.00	05800	MRI	301,357	0	301,357	58.00
59.00	05900	CARDIAC CATHETERIZATION	118,645	0	118,645	59.00
60.00	06000	LABORATORY	95,717	0	95,717	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,246	0	3,246	63.00
64.00	06400	INTRAVENOUS THERAPY	42,083	0	42,083	64.00
65.00	06500	RESPIRATORY THERAPY	40,829	0	40,829	65.00
66.00	06600	PHYSICAL THERAPY	35,909	0	35,909	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,530	0	5,530	67.00
68.00	06800	SPEECH PATHOLOGY	14,540	0	14,540	68.00
69.00	06900	ELECTROCARDIOLOGY	86,770	0	86,770	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	18,322	0	18,322	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	15,119	0	15,119	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	69,579	0	69,579	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	180,546	0	180,546	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
76.00	03610	SLEEP LAB	10,063	0	10,063	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	54,589	0	54,589	90.00
91.00	09100	EMERGENCY	257,333	0	257,333	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,489,543	0	3,489,543	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	29,022	0	29,022	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	126,818	0	126,818	192.00
194.00	07950	VACANT SPACE	6,838	0	6,838	194.00
194.01	07951	LEASED SPACE	35,180	0	35,180	194.01
194.02	07952	FOUNDATION	3,440	0	3,440	194.02
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	-273,659	0	-273,659	201.00
202.00		TOTAL (sum lines 118 through 201)	3,417,182	0	3,417,182	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0120

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:
8/16/2020 12:32 pm

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	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	362,412					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,154,102				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,480	0	15,033,309			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	121,450	15,037	162,954	-12,152,058	34,113,777	5.00
7.00	00700	OPERATION OF PLANT	50,094	1,055,963	536,668	0	3,262,107	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,752	17,247	30,825	0	75,449	8.00
9.00	00900	HOUSEKEEPING	298	5,078	610,121	0	1,020,528	9.00
10.00	01000	DIETARY	7,143	0	294,376	0	191,714	10.00
11.00	01100	CAFETERIA	1,998	0	285,196	0	390,563	11.00
13.00	01300	NURSING ADMINISTRATION	9,646	0	103,535	0	1,049,334	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,200	21,076	319,507	0	462,832	14.00
15.00	01500	PHARMACY	1,720	123,145	771,890	0	1,112,128	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,298	0	0	0	343,541	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	41,412	65,133	2,354,179	0	3,709,516	30.00
31.00	03100	INTENSIVE CARE UNIT	3,986	67,919	587,382	0	822,548	31.00
43.00	04300	NURSERY	1,036	3,155	68,885	0	89,799	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	593,176	2,163,626	0	3,505,933	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,520	13,245	289,228	0	375,428	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,527	270,703	1,345,427	0	2,030,518	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	770	189,847	348,197	0	647,578	57.00
58.00	05800	MRI	2,032	277,332	144,024	0	463,561	58.00
59.00	05900	CARDIAC CATHETERIZATION	765	110,418	65,816	0	221,590	59.00
60.00	06000	LABORATORY	6,019	45,198	728,090	0	1,829,520	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	151,999	63.00
64.00	06400	INTRAVENOUS THERAPY	0	33,300	788,657	0	1,269,949	64.00
65.00	06500	RESPIRATORY THERAPY	1,526	24,398	475,178	0	618,808	65.00
66.00	06600	PHYSICAL THERAPY	3,950	2,241	0	0	426,247	66.00
67.00	06700	OCCUPATIONAL THERAPY	480	676	0	0	143,264	67.00
68.00	06800	SPEECH PATHOLOGY	1,848	780	11,110	0	139,643	68.00
69.00	06900	ELECTROCARDIOLOGY	5,326	40,134	208,067	0	301,001	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	17,772	31,109	0	55,954	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	2,638,621	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,888,337	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,498,670	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03610	SLEEP LAB	740	1,242	23,140	0	59,245	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,021	33,502	482,342	0	690,444	90.00
91.00	09100	EMERGENCY	14,713	126,385	1,685,723	0	2,309,187	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	333,582	3,154,102	14,915,252	-12,152,058	33,795,556	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,988	0	118,057	0	296,296	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,287	0	0	0	16,140	192.00
194.00	07950	VACANT SPACE	986	0	0	0	870	194.00
194.01	07951	LEASED SPACE	5,073	0	0	0	4,477	194.01
194.02	07952	FOUNDATION	496	0	0	0	438	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)	319,854	57,042	-353,844		12,152,058	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.882570	0.018085	0.000000		0.356221	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			-273,659		122,499	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.003591	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 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:
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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 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:
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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	189,388					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,752	314,685				8.00
9.00	00900	HOUSEKEEPING	298	0	185,338			9.00
10.00	01000	DIETARY	7,143	0	7,143	26,280		10.00
11.00	01100	CAFETERIA	1,998	0	1,998	0	24,794	11.00
13.00	01300	NURSING ADMINISTRATION	9,646	0	9,646	0	155	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,200	2,229	5,200	0	859	14.00
15.00	01500	PHARMACY	1,720	1,842	1,720	0	903	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	87,171	41,412	24,291	4,480	30.00
31.00	03100	INTENSIVE CARE UNIT	3,986	5,800	3,986	1,989	1,110	31.00
43.00	04300	NURSERY	1,036	1,383	1,036	0	96	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	74,039	20,832	0	3,637	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,520	5,805	2,520	0	403	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,527	45,302	16,527	0	2,229	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	770	0	770	0	558	57.00
58.00	05800	MRI	2,032	4,373	2,032	0	230	58.00
59.00	05900	CARDIAC CATHETERIZATION	765	0	765	0	107	59.00
60.00	06000	LABORATORY	6,019	74	6,019	0	1,436	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	20,135	0	0	1,349	64.00
65.00	06500	RESPIRATORY THERAPY	1,526	1,169	1,526	0	800	65.00
66.00	06600	PHYSICAL THERAPY	3,950	3,824	3,950	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	480	1,153	480	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,848	686	1,848	0	15	68.00
69.00	06900	ELECTROCARDIOLOGY	5,326	0	5,326	0	343	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	46	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	44	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,021	746	2,021	0	2,969	90.00
91.00	09100	EMERGENCY	14,713	58,954	14,713	0	2,515	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	160,558	314,685	156,508	26,280	24,284	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,988	0	3,988	0	510	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)	4,424,138	189,973	1,391,023	480,480	591,360	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.360181	0.603693	7.505331	18.283105	23.850932	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,134,510	43,617	10,883	50,200	15,252	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.990401	0.138605	0.058720	1.910198	0.615149	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 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:
8/16/2020 12:32 pm

Cost Center Description			NURSING ADMINISTRATION (TOTAL PATI ENT 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	9,051				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,490,029			14.00
15.00	01500	PHARMACY	0	0	1,498,723		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	8,097	317,421	0	17,264	30.00
31.00	03100	INTENSIVE CARE UNIT	663	385	0	839	31.00
43.00	04300	NURSERY	291	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	1,033,480	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	118,715	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	166,538	0	0	57.00
58.00	05800	MRI	0	75,562	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,943	0	0	59.00
60.00	06000	LABORATORY	0	15,591	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	81,187	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	43,665	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	519	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	231,494	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	169,713	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,888,337	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,498,723	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03610	SLEEP LAB	0	103,148	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	17,067	0	0	90.00
91.00	09100	EMERGENCY	0	225,264	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)	9,051	4,490,029	1,498,723	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)	1,724,554	810,037	1,584,029	598,578	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	190.537399	0.180408	1.056919	20.604385	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	70,725	149,319	175,164	31,026	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.814054	0.033256	0.116876	1.067984	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

Worksheet C
Part I
Date/Time Prepared:
8/16/2020 12:32 pm

MCRIF32 - 16.1.168.2

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0120

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/16/2020 12:32 pm

			Title XVIII			Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	16,707,338		16,707,338			30.00
31.00	03100	INTENSIVE CARE UNIT	3,427,338		3,427,338			31.00
43.00	04300	NURSERY	324,174		324,174			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,865,935	54,128,651	65,994,586	0.088547	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,359,093	2,590	1,361,683	0.440675	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,750,611	21,195,416	23,946,027	0.140561	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	5,726,888	30,525,731	36,252,619	0.026078	0.000000	57.00
58.00	05800	MRI	637,626	9,266,627	9,904,253	0.072006	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	79,608	318,388	397,996	0.821719	0.000000	59.00
60.00	06000	LABORATORY	11,338,623	20,444,438	31,783,061	0.085081	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	587,010	416,959	1,003,969	0.219918	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	2,047,906	8,920,285	10,968,191	0.161071	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	5,812,327	1,941,986	7,754,313	0.123165	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,126,851	1,513,153	2,640,004	0.269011	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	342,835	108,178	451,013	0.465406	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	208,579	545,755	754,334	0.327705	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,020,171	5,229,411	7,249,582	0.085875	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	15,083	734,589	749,672	0.102689	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,424,382	7,214,236	12,638,618	0.285567	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,825,078	3,930,880	6,755,958	0.429498	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,389,766	8,668,177	16,057,943	0.225219	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
76.00	03610	SLEEP LAB	0	237,286	237,286	0.517721	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	863,458	6,716,972	7,580,430	0.141564	0.000000	90.00
91.00	09100	EMERGENCY	6,170,825	34,002,260	40,173,085	0.093216	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	366,044	2,567,743	2,933,787	0.540248	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	89,417,549	218,629,711	308,047,260			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	89,417,549	218,629,711	308,047,260			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0120	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepared: 8/16/2020 12:32 pm
			Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio		
			11.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.088547		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.440675		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.140561		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.026078		57.00
58.00	05800	MRI	0.072006		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.821719		59.00
60.00	06000	LABORATORY	0.085081		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.219918		63.00
64.00	06400	INTRAVENOUS THERAPY	0.161071		64.00
65.00	06500	RESPIRATORY THERAPY	0.123165		65.00
66.00	06600	PHYSICAL THERAPY	0.269011		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.465406		67.00
68.00	06800	SPEECH PATHOLOGY	0.327705		68.00
69.00	06900	ELECTROCARDIOLOGY	0.085875		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.102689		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.285567		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.429498		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225219		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03610	SLEEP LAB	0.517721		76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.141946		90.00
91.00	09100	EMERGENCY	0.093216		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.540248		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 01/01/2019
To 12/31/2019Worksheet D
Part I
Date/Time Prepared:
8/16/2020 12:32 pm

			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	520,194	0	520,194	9,859	52.76	30.00
31.00	INTENSIVE CARE UNIT	111,107		111,107	663	167.58	31.00
43.00	NURSERY	14,590		14,590	291	50.14	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	645,891		645,891	10,813		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	4,006	211,357				
31.00	INTENSIVE CARE UNIT	315	52,788				
43.00	NURSERY	0	0				
44.00	SKILLED NURSING FACILITY	0	0				
200.00	Total (lines 30 through 199)	4,321	264,145				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0120	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part II Date/Time Prepared: 8/16/2020 12:32 pm			
				Title XVIII		Hospital			
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)	PPS
				1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	821,773	65,994,586	0.012452	4,016,167	50,009	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	33,354	1,361,683	0.024495	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	22,476	0	0.000000	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	409,032	23,946,027	0.017081	1,391,118	23,762	54.00	
56.00	05600	RADIOISOTOPE	16	0	0.000000	0	0	56.00	
57.00	05700	CT SCAN	206,824	36,252,619	0.005705	2,619,644	14,945	57.00	
58.00	05800	MRI	301,357	9,904,253	0.030427	270,059	8,217	58.00	
59.00	05900	CARDIAC CATHETERIZATION	118,645	397,996	0.298106	54,856	16,353	59.00	
60.00	06000	LABORATORY	95,717	31,783,061	0.003012	5,619,390	16,926	60.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,246	1,003,969	0.003233	350,587	1,133	63.00	
64.00	06400	INTRAVENOUS THERAPY	42,083	10,968,191	0.003837	1,005,430	3,858	64.00	
65.00	06500	RESPIRATORY THERAPY	40,829	7,754,313	0.005265	3,114,640	16,399	65.00	
66.00	06600	PHYSICAL THERAPY	35,909	2,640,004	0.013602	603,883	8,214	66.00	
67.00	06700	OCCUPATIONAL THERAPY	5,530	451,013	0.012261	167,107	2,049	67.00	
68.00	06800	SPEECH PATHOLOGY	14,540	754,334	0.019275	92,927	1,791	68.00	
69.00	06900	ELECTROCARDIOLOGY	86,770	7,249,582	0.011969	1,470,278	17,598	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	18,322	749,672	0.024440	15,083	369	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	15,119	12,638,618	0.001196	2,661,606	3,183	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	69,579	6,755,958	0.010299	1,255,675	12,932	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	180,546	16,057,943	0.011243	3,317,446	37,298	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00	
76.00	03610	SLEEP LAB	10,063	237,286	0.042409	0	0	76.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	54,589	7,580,430	0.007201	427,829	3,081	90.00	
91.00	09100	EMERGENCY	257,333	40,173,085	0.006406	2,870,714	18,390	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92,968	2,933,787	0.031689	176,618	5,597	92.00	
200.00		Total (lines 50 through 199)	2,936,620	287,588,410		31,501,057	262,104	200.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0120		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part III Date/Time Prepared: 8/16/2020 12:32 pm	
					Title XVIII		Hospital		PPS	
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00	
43.00	04300	NURSERY	0	0	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	44.00	
200.00		Total (lines 30 through 199)	0	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	9,859	0.00	4,006	30.00		
31.00	03100	INTENSIVE CARE UNIT		0	663	0.00	315	31.00		
43.00	04300	NURSERY		0	291	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	10,813		4,321	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 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/16/2020 12:32 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	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	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 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/16/2020 12:32 pm	
			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) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	65,994,586	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,361,683	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	23,946,027	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	36,252,619	0.000000	57.00
58.00	05800	MRI	0	0	0	9,904,253	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	397,996	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	31,783,061	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,003,969	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	10,968,191	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,754,313	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,640,004	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	451,013	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	754,334	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	7,249,582	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	749,672	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	12,638,618	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,755,958	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	16,057,943	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	237,286	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	7,580,430	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	40,173,085	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,933,787	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	287,588,410		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0120

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/16/2020 12:32 pm

				Title XVIII		Hospital	PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	4,016,167	0	12,011,270	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	1,391,118	0	5,157,028	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	2,619,644	0	8,679,244	0	57.00
58.00	05800	MRI	0.000000	270,059	0	2,510,216	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	54,856	0	137,140	0	59.00
60.00	06000	LABORATORY	0.000000	5,619,390	0	2,998,268	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	350,587	0	173,702	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	1,005,430	0	1,931,293	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	3,114,640	0	602,404	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	603,883	0	47,009	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	167,107	0	14,222	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	92,927	0	2,702	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,470,278	0	2,310,440	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	15,083	0	241,378	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	2,661,606	0	2,161,276	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,255,675	0	1,295,171	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	3,317,446	0	2,605,350	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03610	SLEEP LAB	0.000000	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	427,829	0	2,158,014	0	90.00
91.00	09100	EMERGENCY	0.000000	2,870,714	0	5,726,554	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	176,618	0	534,072	0	92.00
200.00		Total (lines 50 through 199)		31,501,057	0	51,296,753	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0120	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Prepared: 8/16/2020 12:32 pm		
				Title XVIII	Hospital	PPS		
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.088547	12,011,270	0	0	1,063,562	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.440675	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	5,157,028	0	0	724,877	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.026078	8,679,244	0	0	226,337	57.00
58.00	05800	MRI	0.072006	2,510,216	0	0	180,751	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.821719	137,140	0	0	112,691	59.00
60.00	06000	LABORATORY	0.085081	2,998,268	0	0	255,096	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.219918	173,702	0	0	38,200	63.00
64.00	06400	INTRAVENOUS THERAPY	0.161071	1,931,293	0	0	311,075	64.00
65.00	06500	RESPIRATORY THERAPY	0.123165	602,404	0	0	74,195	65.00
66.00	06600	PHYSICAL THERAPY	0.269011	47,009	0	0	12,646	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.465406	14,222	0	0	6,619	67.00
68.00	06800	SPEECH PATHOLOGY	0.327705	2,702	0	0	885	68.00
69.00	06900	ELECTROCARDIOLOGY	0.085875	2,310,440	0	0	198,409	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.102689	241,378	0	0	24,787	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.285567	2,161,276	0	0	617,189	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.429498	1,295,171	0	0	556,273	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225219	2,605,350	0	6,630	586,774	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03610	SLEEP LAB	0.517721	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.141564	2,158,014	0	0	305,497	90.00
91.00	09100	EMERGENCY	0.093216	5,726,554	0	0	533,806	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.540248	534,072	0	0	288,531	92.00
200.00		Subtotal (see instructions)		51,296,753	0	6,630	6,118,200	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		51,296,753	0	6,630	6,118,200	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0120		Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Prepared: 8/16/2020 12:32 pm
			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
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	1,493		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	1,493		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,493		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0120	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/16/2020 12:32 pm	
Title XVIII		Hospital		PPS	
Cost Center Description				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			9,859	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			9,859	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)			8,097	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) (see instructions)			4,006	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)			8,868,487	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0	25.00
26.00	Total swing-bed cost (see instructions)			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			8,868,487	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			8,868,487	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)			899.53	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			3,603,517	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)			3,603,517	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0120

Period:
From 01/01/2019
To 12/31/2019

Worksheet D-1

Date/Time Prepared:
8/16/2020 12:32 pm

		Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
	Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT	1,448,610	663	2,184.93	315	688,253
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
	Cost Center Description					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					4,653,516
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					8,945,286
	PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					264,145
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					262,104
52.00	Total Program excludable cost (sum of lines 50 and 51)					526,249
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					8,419,037
	TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
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
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
	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
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
	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)					1,762
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					899.53
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,584,972

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0120

Period:
From 01/01/2019
To 12/31/2019

Worksheet D-1

Date/Time Prepared:
8/16/2020 12:32 pm

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	520,194	8,868,487	0.058656	1,584,972	92,968	90.00
91.00 Nursing School cost	0	8,868,487	0.000000	1,584,972	0	91.00
92.00 Allied health cost	0	8,868,487	0.000000	1,584,972	0	92.00
93.00 All other Medical Education	0	8,868,487	0.000000	1,584,972	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0120	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 8/16/2020 12:32 pm	
			Title XVIII	Hospital	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		8,832,449		30.00
31.00	03100	INTENSIVE CARE UNIT		1,666,905		31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.088547	4,016,167	355,620	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.440675	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.140561	1,391,118	195,537	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.026078	2,619,644	68,315	57.00
58.00	05800	MRI	0.072006	270,059	19,446	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.821719	54,856	45,076	59.00
60.00	06000	LABORATORY	0.085081	5,619,390	478,103	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.219918	350,587	77,100	63.00
64.00	06400	INTRAVENOUS THERAPY	0.161071	1,005,430	161,946	64.00
65.00	06500	RESPIRATORY THERAPY	0.123165	3,114,640	383,615	65.00
66.00	06600	PHYSICAL THERAPY	0.269011	603,883	162,451	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.465406	167,107	77,773	67.00
68.00	06800	SPEECH PATHOLOGY	0.327705	92,927	30,453	68.00
69.00	06900	ELECTROCARDIOLOGY	0.085875	1,470,278	126,260	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.102689	15,083	1,549	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.285567	2,661,606	760,067	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.429498	1,255,675	539,310	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225219	3,317,446	747,152	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
76.00	03610	SLEEP LAB	0.517721	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.141946	427,829	60,729	90.00
91.00	09100	EMERGENCY	0.093216	2,870,714	267,596	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.540248	176,618	95,418	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		31,501,057	4,653,516	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)		31,501,057		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0120

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A
Date/Time Prepared:
8/16/2020 12:32 pm

		Title XVIII	Hospital	PPS	
				1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			6,381,509	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			1,448,826	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)			0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)			0	1.04
2.00	Outlier payments for discharges. (see instructions)				2.00
2.01	Outlier reconciliation amount			0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)			0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)			406,178	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			21,516	2.04
3.00	Managed Care Simulated Payments			0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			98.16	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)			4.41	30.00
31.00	Percentage of Medicaid patient days (see instructions)			11.63	31.00
32.00	Sum of lines 30 and 31			16.04	32.00
33.00	Allowable disproportionate share percentage (see instructions)			3.18	33.00
34.00	Disproportionate share adjustment (see instructions)			62,251	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0120	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/16/2020 12:32 pm	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)		0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		513,051	517,364	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		383,734	130,048	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		513,782		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 and 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 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 and 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)		8,834,062		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)			8,834,062	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			662,355	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 instructions)			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)			9,496,417	59.00
60.00	Primary payer payments			16,461	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			9,479,956	61.00
62.00	Deductibles billed to program beneficiaries			1,007,684	62.00
63.00	Coinurance billed to program beneficiaries			10,230	63.00
64.00	Allowable bad debts (see instructions)			128,916	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			83,795	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			8,545,837	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)			0	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)			25,870	70.93
70.94	HRR adjustment amount (see instructions)			-149,791	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0120	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/16/2020 12:32 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		93,725	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		8,328,191	71.00
71.01	Sequestration adjustment (see instructions)		166,564	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		8,094,412	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		67,215	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
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	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	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	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
Comparison 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 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
8/16/2020 12:32 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	6,381,509	0	6,381,509		6,381,509
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,448,826	0		1,448,826	1,448,826
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	406,178	0	406,178		406,178
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	21,516	0		21,516	21,516
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	0	0	0
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	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
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	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0318	0.0318	0.0318	0.0318	
11.00	Disproportionate share adjustment (see instructions)	34.00	62,251	0	50,733	11,518	62,251
11.01	Uncompensated care payments	36.00	513,782	0	383,734	130,048	513,782
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	8,834,062	0	7,222,154	1,611,908	8,834,062
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	8,834,062	0	7,222,154	1,611,908	8,834,062
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	662,355	0	546,770	115,585	662,355

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0120

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
8/16/2020 12:32 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0
17.01	Net organ aquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	7,768,924	1,727,493	9,496,417
		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	629,375	0	515,223	114,152	629,375
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	32,980	0	31,547	1,433	32,980
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0
26.00	Total prospective capital payments (see instructions)	12.00	662,355	0	546,770	115,585	662,355
		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	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0120

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
8/16/2020 12:32 pm

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	6,381,509	6,381,509		6,381,509	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,448,826		1,448,826	1,448,826	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	406,178	406,178		406,178	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	21,516		21,516	21,516	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0318	0.0318	0.0318		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	62,251	50,733	11,518	62,251	11.00
11.01	Uncompensated care payments	36.00	513,782	383,734	130,048	513,782	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	8,834,062	7,222,154	1,611,908	8,834,062	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	8,834,062	7,222,154	1,611,908	8,834,062	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	662,355	546,770	115,585	662,355	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			7,768,924	1,727,493	9,496,417	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0120

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
8/16/2020 12:32 pm

		Title XVIII		Hospital		PPS	
		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	629,375	515,223	114,152	629,375	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	32,980	31,547	1,433	32,980	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	662,355	546,770	115,585	662,355	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	25,870	24,837	1,033	25,870	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	-149,791	-121,250	-28,541	-149,791	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		76,725	17,000	93,725	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 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 8/16/2020 12:32 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		1,493	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		6,118,200	2.00
3.00	OPPS payments		5,870,575	3.00
4.00	Outlier payment (see instructions)		10,013	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)		1,493	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		6,630	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)		6,630	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)		6,630	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		5,137	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)		1,493	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)		5,880,588	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,173,423	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)		4,708,658	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)		4,708,658	30.00
31.00	Primary payer payments		603	31.00
32.00	Subtotal (line 30 minus line 31)		4,708,055	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)		142,216	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		92,440	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		4,800,495	37.00
38.00	MSP-LCC reconciliation amount from PS&R		11	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)		895	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		4,800,484	40.00
40.01	Sequestration adjustment (see instructions)		96,010	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		4,660,025	41.00
41.01	Interim payments-PARHM			41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)		44,449	43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
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)			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 01/01/2019
To 12/31/2019Worksheet E-1
Part I
Date/Time Prepared:
8/16/2020 12:32 pm

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		8,155,262		4,690,805	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		08/26/2019	60,850	08/26/2019	30,780	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-60,850		-30,780	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)		8,094,412		4,660,025	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		67,215		44,449	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		8,161,627		4,704,474	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 01/01/2019 To 12/31/2019	Worksheet E-1 Part II Date/Time Prepared: 8/16/2020 12:32 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

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

Provider CCN: 14-0120

Period:
From 01/01/2019
To 12/31/2019

Worksheet G

Date/Time Prepared:
8/16/2020 12:32 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	977,023	0	0	0	1.00
2.00	Temporary investments	2,370,290	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,249,613	0	0	0	4.00
5.00	Other receivable	775,373	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,513,520	0	0	0	7.00
8.00	Prepaid expenses	116,643	0	0	0	8.00
9.00	Other current assets	255,358	0	0	0	9.00
10.00	Due from other funds	12,504,190	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	25,762,010	0	0	0	11.00
FIXED ASSETS						
12.00	Land	4,206,871	0	0	0	12.00
13.00	Land improvements	9,034,318	0	0	0	13.00
14.00	Accumulated depreciation	-989,162	0	0	0	14.00
15.00	Buildings	789,587	0	0	0	15.00
16.00	Accumulated depreciation	0	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	40,368,366	0	0	0	19.00
20.00	Accumulated depreciation	-1,676,941	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	-26,995,908	0	0	0	23.00
24.00	Accumulated depreciation	-1,503,873	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)	23,233,258	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	2,906,789	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)	2,906,789	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	51,902,057	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,072,566	0	0	0	37.00
38.00	Salaries, wages, and fees payable	727,173	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	0	0	0	42.00
43.00	Due to other funds	7,650,080	0	0	0	43.00
44.00	Other current liabilities	1,523,297	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	11,973,116	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	16,853,940	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	16,853,940	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	28,827,056	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	23,075,001	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	23,075,001	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	51,902,057	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0120

Period:
From 01/01/2019
To 12/31/2019

Worksheet G-1

Date/Time Prepared:
8/16/2020 12:32 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		1,342,681,947		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3,782,906				2.00
3.00	Total (sum of line 1 and line 2)		1,346,464,853		0		3.00
4.00	CHANGE IN TEMP OR PERM REST	5,866,980		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)		5,866,980		0		10.00
11.00	Subtotal (line 3 plus line 10)		1,352,331,833		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		1,352,331,833		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	CHANGE IN TEMP OR PERM REST		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0120

Period:
From 01/01/2019
To 12/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
8/16/2020 12:32 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	19,946,347		19,946,347	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)	19,946,347		19,946,347	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,614,355		3,614,355	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)	3,614,355		3,614,355	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	23,560,702		23,560,702	17.00
18.00	Ancillary services	66,086,822		66,086,822	18.00
19.00	Outpatient services	0	220,624,465	220,624,465	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	89,647,524	220,624,465	310,271,989	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		39,304,579		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)		39,304,579		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0120

Period:
From 01/01/2019
To 12/31/2019

Worksheet G-3

Date/Time Prepared:
8/16/2020 12:32 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	310,271,989	1.00
2.00	Less contractual allowances and discounts on patients' accounts	257,064,719	2.00
3.00	Net patient revenues (line 1 minus line 2)	53,207,270	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	39,304,579	4.00
5.00	Net income from service to patients (line 3 minus line 4)	13,902,691	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	278,689	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	282,019	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 AND HOME OFFICE REVENUE	128,850	24.00
25.00	Total other income (sum of lines 6-24)	689,558	25.00
26.00	Total (line 5 plus line 25)	14,592,249	26.00
27.00	PEORIA HOME OFFICE EXPENSES	10,809,343	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	10,809,343	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	3,782,906	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0120	Period: From 01/01/2019 To 12/31/2019	Worksheet L Parts I-III Date/Time Prepared: 8/16/2020 12:32 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		629,375	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		32,980	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)		24.99	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		662,355	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