

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050 EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 26-2010	Period: From 09/01/2016 To 08/31/2017	Worksheet S Parts I-III Date/Time Prepared: 1/22/2018 10:20 am
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PART I - COST REPORT STATUS

Provider use only
 1. Electronically filed cost report
 2. Manually submitted 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.

Date: 1/22/2018 Time: 10:20 am

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 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 Kindred Hospital St. Louis (26-2010) for the cost reporting period beginning 09/01/2016 and ending 08/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

SR VICE PRESIDENT OF REIMBURSEMENT
 Title _____
 01/22/2018
 Date _____

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	10,877	3,311	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
200.00 Total	0	10,877	3,311	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: 26-2010		Period: From 09/01/2016 To 08/31/2017		Worksheet S-2 Part I Date/Time Prepared: 1/22/2018 10:19 am						
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 4930 Lindell Boulevard			PO Box:						1.00		
2.00	City: St. Louis			State: MO		Zip Code: 63108		County: ST. LOUIS CITY		2.00		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		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		Kindred Hospital St. Louis		262010	41180	2	08/30/1991	N	P	O	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:		To:			
							1.00		2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						09/01/2016		08/31/2017		20.00	
21.00	Type of Control (see instructions)						4				21.00	
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (PickLe amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N		N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						N		N		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N		N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N		N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.								2		N	23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
				1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	0	0	0	0	0		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.			0	0	0	0	0	0		25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-2010	Period: From 09/01/2016 To 08/31/2017	Worksheet S-2 Part I Date/Time Prepared: 1/22/2018 10:19 am			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00	
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N				37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N		N		39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N		N		40.00	
		V	XVII	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		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		46.00	
47.00	Is this a new hospital under 42 CFR 412.300 PPS capital? Enter "Y" for yes or "N" for no.	N		N		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N		N		48.00	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under 413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			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)		0.00	0.00			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)		0.00	0.00			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).		0.00	0.00			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)		0.00	0.00			61.05

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	Y/N	IME	Direct GME	IME	Direct GME					
	1.00	2.00	3.00	4.00	5.00					
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)						0.00	0.00	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 and enter in column 4, 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 and enter in column 4, direct GME FTE unweighted count.						0.00	0.00	61.20	
						1.00				
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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 64-67. (see instructions)						N	63.00		
	Program Name		Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))				
	1.00	2.00	3.00	4.00	5.00					
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
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

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000
				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 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	76.00
				1.00		
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				Y	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.				Y	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 a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? 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

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		1.00	2.00				
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.						134.00
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	189003				140.00
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: KINDRED HEALTHCARE OPERATING INC.	Contractor's Name: WISCONSIN PHYSICIANS SERVICES		Contractor's Number: 05901			141.00
142.00	Street: 680 SOUTH FOURTH AVENUE	PO Box:		Zip Code: 40202			142.00
143.00	City: LOUISVILLE	State: KY					143.00
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y				144.00
		1.00	2.00				
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y					145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N					146.00
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N				147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N				148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N				149.00
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N		155.00
156.00	Subprovider - IPF	N	N	N	N		156.00
157.00	Subprovider - IRF	N	N	N	N		157.00
158.00	SUBPROVIDER						158.00
159.00	SNF	N	N	N	N		159.00
160.00	HOME HEALTH AGENCY	N	N	N	N		160.00
161.00	CMHC	N	N	N	N		161.00
						1.00	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.		N				165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
166.01							0.00
166.02							0.00
166.03							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.		N				167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0
168.01	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-2010	Period: From 09/01/2016 To 08/31/2017	Worksheet S-2 Part I Date/Time Prepared: 1/22/2018 10:19 am
			Beginning	Ending
			1.00	2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			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. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 26-2010		Period: From 09/01/2016 To 08/31/2017		Worksheet S-2 Part II Date/Time Prepared: 1/22/2018 10:19 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
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)	Y					3.00
		Y/N	Type				
		1.00	2.00				
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		03/31/2018		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					1.00
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				N		14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				Y		15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	11/30/2017	Y	11/30/2017		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 26-2010	Period: From 09/01/2016 To 08/31/2017	Worksheet S-2 Part II Date/Time Prepared: 1/22/2018 10:19 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N	N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		Y	12/31/2017	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00		2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAVID		SIMPSON	41.00
42.00	Enter the employer/company name of the cost report preparer.	KINDRED HEALTHCARE OPERATING INC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5025967945		KindredReimbursement@kindred.com	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 26-2010

Period:
From 09/01/2016
To 08/31/2017

Worksheet S-2
Part II
Date/Time Prepared:
1/22/2018 10:19 am

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT MANAGER	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: 26-2010

Period:
From 09/01/2016
To 08/31/2017

Worksheet S-3
Part I
Date/Time Prepared:
1/22/2018 10:19 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	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	92	33,580	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)		92	33,580	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	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						13.00
14.00 Total (see instructions)		92	33,580	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						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)		92				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 26-2010

Period:
From 09/01/2016
To 08/31/2017

Worksheet S-3
Part I
Date/Time Prepared:
1/22/2018 10:19 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	11,182	2,559	20,213			1.00
2.00 HMO and other (see instructions)	1,916	120				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	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	11,182	2,559	20,213			7.00
8.00 INTENSIVE CARE UNIT	0	0	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						13.00
14.00 Total (see instructions)	11,182	2,559	20,213	0.00	180.60	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						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	180.60	27.00
28.00 Observation Bed Days		0	0			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	209					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 26-2010

Period:
From 09/01/2016
To 08/31/2017

Worksheet S-3
Part I
Date/Time Prepared:
1/22/2018 10:19 am

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
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	453	83	762	1.00
2.00 HMO and other (see instructions)			66	5		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	453	83	762	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						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						33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 26-2010

Period:
From 09/01/2016
To 08/31/2017

Worksheet S-3
Part II
Date/Time Prepared:
1/22/2018 10:19 am

	Worksheet A Line Number	Amount Reported	Reclassifi- cation 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 II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	11,202,255	-2,873	11,199,382	375,139.57	29.85
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)		0	70,411	70,411	1,843.00	38.20
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		4,968,306	0	4,968,306	87,538.00	56.76
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		538,030	0	538,030	5,275.00	102.00
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		1,511,770	0	1,511,770	35,305.00	42.82
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
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		1,819,980	0	1,819,980		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		11,811	0	11,811		
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		0	0	0		
25.51	Related organization wage-related		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	121,275	0	121,275	2,488.30	48.74
27.00	Administrative & General	5.00	1,755,108	0	1,755,108	39,850.61	44.04

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 26-2010

Period:
From 09/01/2016
To 08/31/2017

Worksheet S-3
Part II
Date/Time Prepared:
1/22/2018 10:19 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati 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	
28.00	Administrative & General under contract (see inst.)	7,619	0	7,619	227.96	33.42	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	223,887	0	223,887	14,774.00	15.15	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	129,559	0	129,559	4,712.00	27.50	34.00
35.00	Dietary under contract (see instructions)	0	0	0	0.00	0.00	35.00
36.00	Cafeteria	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	1,271,185	0	1,271,185	30,310.00	41.94	38.00
39.00	Central Services and Supply	105,452	0	105,452	6,522.00	16.17	39.00
40.00	Pharmacy	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	426,986	0	426,986	14,825.00	28.80	41.00
42.00	Social Service	885,545	-70,411	815,134	21,267.00	38.33	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 26-2010

Period:
From 09/01/2016
To 08/31/2017

Worksheet S-3
Part III
Date/Time Prepared:
1/22/2018 10:19 am

	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	11,209,874	-2,873	11,207,001	375,367.53	29.86	1.00
2.00	Excluded area salaries (see instructions)	0	70,411	70,411	1,843.00	38.20	2.00
3.00	Subtotal salaries (line 1 minus line 2)	11,209,874	-73,284	11,136,590	373,524.53	29.81	3.00
4.00	Subtotal other wages & related costs (see inst.)	7,018,106	0	7,018,106	128,118.00	54.78	4.00
5.00	Subtotal wage-related costs (see inst.)	1,819,980	0	1,819,980	0.00	16.34	5.00
6.00	Total (sum of lines 3 thru 5)	20,047,960	-73,284	19,974,676	501,642.53	39.82	6.00
7.00	Total overhead cost (see instructions)	4,926,616	-70,411	4,856,205	134,976.87	35.98	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 26-2010	Period: From 09/01/2016 To 08/31/2017	Worksheet S-3 Part IV Date/Time Prepared: 1/22/2018 10:19 am
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	6,784	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration Fees	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)	599,069	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	2,099	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	6,352	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)	57,041	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	274,977	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	788,292	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	71,418	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	13,948	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	1,819,980	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 26-2010	Period: From 09/01/2016 To 08/31/2017	Worksheet S-3 Part V Date/Time Prepared: 1/22/2018 10:19 am
Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	4,968,306	1,819,980	1.00
2.00	Hospital	4,968,306	1,819,980	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			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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 26-2010	Period: From 09/01/2016 To 08/31/2017	Worksheet A Date/Time Prepared: 1/22/2018 10:19 am		
Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified 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		2,119,355	2,119,355	89,025	2,208,380	1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		863,202	863,202	150,864	1,014,066	2.00
3.00 00300	OTHER CAP REL COSTS		239,889	239,889	-239,889	0	3.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	121,275	1,932,458	2,053,733	0	2,053,733	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	1,755,108	6,043,452	7,798,560	9,975	7,808,535	5.00
7.00 00700	OPERATION OF PLANT	0	1,066,587	1,066,587	-44,927	1,021,660	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	126,446	126,446	0	126,446	8.00
9.00 00900	HOUSEKEEPING	223,887	102,356	326,243	287	326,530	9.00
10.00 01000	DIETARY	129,559	587,526	717,085	7,923	725,008	10.00
11.00 01100	CAFETERIA	0	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	1,271,185	39,374	1,310,559	203	1,310,762	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	105,452	18,190	123,642	276,529	400,171	14.00
15.00 01500	PHARMACY	0	1,253,932	1,253,932	2,927	1,256,859	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	426,986	104,751	531,737	11	531,748	16.00
17.00 01700	SOCIAL SERVICE	885,545	48,157	933,702	-74,366	859,336	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	4,491,897	3,416,734	7,908,631	514,854	8,423,485	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	215,276	161,052	376,328	0	376,328	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	78,649	305,299	383,948	7,305	391,253	54.00
60.00 06000	LABORATORY	79,525	411,714	491,239	6,167	497,406	60.00
65.00 06500	RESPIRATORY THERAPY	1,416,602	67,797	1,484,399	240,065	1,724,464	65.00
66.00 06600	PHYSICAL THERAPY	1,309	1,281,797	1,283,106	9,808	1,292,914	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
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,302,119	1,302,119	-1,031,130	270,989	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	1,682,430	1,682,430	0	1,682,430	73.00
74.00 07400	RENAL DIALYSIS	0	686,229	686,229	0	686,229	74.00
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
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00 09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	11,202,255	23,860,846	35,063,101	-74,369	34,988,732	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00 07950	NONALLOWABLE CLINICAL LIAISON	0	0	0	74,369	74,369	194.00
194.01 07951	IDLE SPACE	0	0	0	0	0	194.01
194.02 07952	REGIONAL OFFICE	0	0	0	0	0	194.02
194.03 07953	DISTRICT OFFICE	0	0	0	0	0	194.03
194.04 07954	NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
194.05 07955	REG NURSG OFFICE	0	0	0	0	0	194.05
194.06 07956	CONTACT CENTER	0	0	0	0	0	194.06
194.07 07957	CENTRALIZED ADMINISTRATIONS DEPT	0	0	0	0	0	194.07
194.08 07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.08
194.09 07958	VISITOR MEALS	0	0	0	0	0	194.09
194.10 07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11 07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
200.00	TOTAL (SUM OF LINES 118-199)	11,202,255	23,860,846	35,063,101	0	35,063,101	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 26-2010

Period:
From 09/01/2016
To 08/31/2017

Worksheet A
Date/Time Prepared:
1/22/2018 10:19 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	39,757	2,248,137	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-98,236	915,830	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,851	2,050,882	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-686,207	7,122,328	5.00
7.00	00700	OPERATION OF PLANT	-1,517	1,020,143	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	126,446	8.00
9.00	00900	HOUSEKEEPING	0	326,530	9.00
10.00	01000	DIETARY	-1,862	723,146	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,310,762	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	400,171	14.00
15.00	01500	PHARMACY	0	1,256,859	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-649	531,099	16.00
17.00	01700	SOCIAL SERVICE	0	859,336	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-265,634	8,157,851	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	376,328	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-74,182	317,071	54.00
60.00	06000	LABORATORY	0	497,406	60.00
65.00	06500	RESPIRATORY THERAPY	-2,365	1,722,099	65.00
66.00	06600	PHYSICAL THERAPY	-92,584	1,200,330	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	270,989	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,682,430	73.00
74.00	07400	RENAL DIALYSIS	-33,186	653,043	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,219,516	33,769,216	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	74,369	194.00
194.01	07951	IDLE SPACE	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	194.05
194.06	07956	CONTACT CENTER	0	0	194.06
194.07	07957	CENTRALIZED ADMINISTRATIONS DEPT	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	194.11
200.00		TOTAL (SUM OF LINES 118-199)	-1,219,516	33,843,585	200.00

RECLASSIFICATIONS

Provider CCN: 26-2010

Period:
From 09/01/2016
To 08/31/2017

Worksheet A-6

Date/Time Prepared:
1/22/2018 10:19 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - RECLASS NON ALLOWABLE CASE MANAGER						
1.00	NONALLOWABLE CLINICAL	194.00	70,411	3,958	1.00	
	LIASON					
	TOTALS		70,411	3,958		
B - RECLASS OXYGEN						
1.00	RESPIRATORY THERAPY	65.00	0	51,834	1.00	
	TOTALS		0	51,834		
C - RECLASS NON-CHARGEABLE MED SUPPLIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	9,975	1.00	
2.00	OPERATION OF PLANT	7.00	0	277	2.00	
3.00	HOUSEKEEPING	9.00	0	287	3.00	
4.00	DIETARY	10.00	0	7,923	4.00	
5.00	NURSING ADMINISTRATION	13.00	0	203	5.00	
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	276,529	6.00	
7.00	PHARMACY	15.00	0	2,927	7.00	
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	11	8.00	
9.00	SOCIAL SERVICE	17.00	0	3	9.00	
10.00	ADULTS & PEDIATRICS	30.00	0	514,854	10.00	
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	54	11.00	
12.00	LABORATORY	60.00	0	6,167	12.00	
13.00	RESPIRATORY THERAPY	65.00	0	150,278	13.00	
14.00	PHYSICAL THERAPY	66.00	0	9,808	14.00	
	TOTALS		0	979,296		
D - RECLASS NON-ALLOW SALARY TO OTHER						
1.00	RESPIRATORY THERAPY	65.00	0	2,873	1.00	
	TOTALS		0	2,873		
E - RECLASS EQUIPMENT SERVICE CONTRACTS						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	7,251	1.00	
2.00	RESPIRATORY THERAPY	65.00	0	37,953	2.00	
	TOTALS		0	45,204		
500.00	Grand Total: Increases		70,411	1,083,165	500.00	

RECLASSIFICATIONS

Provider CCN: 26-2010

Period:
From 09/01/2016
To 08/31/2017

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		
A - RECLASS NON ALLOWABLE CASE MANAGER						
1.00	SOCIAL SERVICE	17.00	70,411	3,958	0	1.00
	TOTALS		70,411	3,958		
B - RECLASS OXYGEN						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	51,834	0	1.00
	TOTALS		0	51,834		
C - RECLASS NON-CHARGEABLE MED SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	9,975	0	1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	277	0	2.00
3.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	287	0	3.00
4.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	7,923	0	4.00
5.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	203	0	5.00
6.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	276,529	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,927	0	7.00
8.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	11	0	8.00
9.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3	0	9.00
10.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	514,854	0	10.00
11.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	54	0	11.00
12.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	6,167	0	12.00
13.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	150,278	0	13.00
14.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	9,808	0	14.00
	TOTALS		0	979,296		
D - RECLASS NON-ALLOW SALARY TO OTHER						
1.00	RESPIRATORY THERAPY	65.00	2,873	0	0	1.00
	TOTALS		2,873	0		
E - RECLASS EQUIPMENT SERVICE CONTRACTS						
1.00	OPERATION OF PLANT	7.00	0	45,204	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		0	45,204		
500.00	Grand Total: Decreases		73,284	1,080,292		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-2010

Period:
From 09/01/2016
To 08/31/2017

Worksheet 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		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	3.00
4.00	Building Improvements	3,006,631	447,149	0	447,149	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	5,719,579	1,337,589	0	1,337,589	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	8,726,210	1,784,738	0	1,784,738	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	8,726,210	1,784,738	0	1,784,738	10.00
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	0	0			3.00
4.00	Building Improvements	3,453,780	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	5,852,801	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	9,306,581	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	9,306,581	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-2010

Period:
From 09/01/2016
To 08/31/2017

Worksheet A-7
Part II
Date/Time Prepared:
1/22/2018 10:19 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	242,070	1,877,285	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	365,434	497,768	0	0	0	2.00
3.00	Total (sum of lines 1-2)	607,504	2,375,053	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	2,119,355				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	863,202				2.00
3.00	Total (sum of lines 1-2)	0	2,982,557				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-2010

Period:
From 09/01/2016
To 08/31/2017

Worksheet A-7
Part III
Date/Time Prepared:
1/22/2018 10:19 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	3,453,780	0	3,453,780	0.371112	9,023	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,852,801	0	5,852,801	0.628888	15,291	2.00
3.00	Total (sum of lines 1-2)	9,306,581	0	9,306,581	1.000000	24,314	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	80,002	0	89,025	290,094	1,877,285	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	135,573	0	150,864	267,198	497,768	2.00
3.00	Total (sum of lines 1-2)	215,575	0	239,889	557,292	2,375,053	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	756	80,002	0	2,248,137	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	15,291	135,573	0	915,830	2.00
3.00	Total (sum of lines 1-2)	0	16,047	215,575	0	3,163,967	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 26-2010

Period:
From 09/01/2016
To 08/31/2017

Worksheet A-8

Date/Time Prepared:
1/22/2018 10:19 am

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
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-8,102		ADMINISTRATIVE & GENERAL	5.00	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)	B	-1,081		CAP REL COSTS-BLDG & FIXT	1.00	9	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-40,190		ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)	A	-1,517		OPERATION OF PLANT	7.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-373,971				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	581,454				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-127		DIETARY	10.00	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	-2,988		MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines	B	-1,735		DIETARY	10.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00			0		0.00	0	33.00
33.01 MISCELLANEOUS INCOME	B	-72,549		ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 26-2010

Period:
From 09/01/2016
To 08/31/2017

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			
			Cost Center	Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00
33.02		0		0.00	0	33.02
33.03		0		0.00	0	33.03
33.04		0		0.00	0	33.04
33.05	OCCUPATIONAL INCENTIVE INCOME	-48,207	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	PATIENT PERSONAL SERVICES EXPENSE	-35	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07		0		0.00	0	33.07
33.08	MEDICARE BAD DEBT - PART A	-804,608	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09		0		0.00	0	33.09
33.10	OTHER MEDICARE NON ALLOWABLE	-75,469	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	OTHER OPERATING - PATIENT RELATIONS	-2,969	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	OTHER OPERATING - PUBLIC RELATIONS	-684	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	OTHER OPERATING - MARKETING	-100,155	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	OTHER OPERATING - INTEREST	-60	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15		0		0.00	0	33.15
33.16		0		0.00	0	33.16
33.17		0		0.00	0	33.17
33.18		0		0.00	0	33.18
33.19		0		0.00	0	33.19
33.20	OTHER OPERATING - TRADE SHOW BOOTH	-1,022	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21		0		0.00	0	33.21
33.22		0		0.00	0	33.22
33.23	CHARITABLE CONTRIBUTIONS	-15,000	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24		0		0.00	0	33.24
33.25		0		0.00	0	33.25
33.26		0		0.00	0	33.26
33.27		0		0.00	0	33.27
33.28	AGGREGATE CAPITAL EROSION	-14,429	ADMINISTRATIVE & GENERAL	5.00	0	33.28
33.29	CABLE TV AND SATELLITE	-8,178	ADMINISTRATIVE & GENERAL	5.00	0	33.29
33.30		0		0.00	0	33.30
33.31		0		0.00	0	33.31
33.32	RENT - OTHER	-63,866	ADMINISTRATIVE & GENERAL	5.00	0	33.32
33.33		0		0.00	0	33.33
33.34	MALPRACTICE TAIL LIABILITY	-43,291	ADMINISTRATIVE & GENERAL	5.00	0	33.34
33.35		0		0.00	0	33.35
33.36		0		0.00	0	33.36
33.37	PHYSICIAN BILLING COLLECTION FEES	-86	ADMINISTRATIVE & GENERAL	5.00	0	33.37
33.38		0		0.00	0	33.38
33.39		0		0.00	0	33.39
33.40		0		0.00	0	33.40
33.41		0		0.00	0	33.41
33.42		0		0.00	0	33.42
33.43	DISTRICT OFFICE SALES AND MARKETING	-34,698	ADMINISTRATIVE & GENERAL	5.00	0	33.43
33.44	DISTRICT OFC SALES AND MKT BENEFITS	-2,579	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.44
33.45	BUSINESS INTERRUPTIONS INS PREMIUM	-8,267	CAP REL COSTS-BLDG & FIXT	1.00	12	33.45
34.00	MEDICARE VS BOOK BLDG	40,672	CAP REL COSTS-BLDG & FIXT	1.00	9	34.00
34.01	MEDICARE VS BOOK MOV EQUIP	-89,042	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.01
34.02		0		0.00	0	34.02
34.03	ASSET ADD-ON BLDG	8,433	CAP REL COSTS-BLDG & FIXT	1.00	9	34.03
34.04	ASSET ADD-ON MOV EQUIP	26,309	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.04
34.05		0		0.00	0	34.05
34.06		0		0.00	0	34.06
34.07		0		0.00	0	34.07
34.08	NON ALLOWABLE LOBBYING FEES	-12,765	ADMINISTRATIVE & GENERAL	5.00	0	34.08
34.09		0		0.00	0	34.09
34.10		0		0.00	0	34.10
34.11		0		0.00	0	34.11
34.12		0		0.00	0	34.12
34.13	PATIENT PHONE - DEPREC EQUIP	-3,432	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.13
34.14		0		0.00	0	34.14
34.15		0		0.00	0	34.15
34.16		0		0.00	0	34.16

ADJUSTMENTS TO EXPENSES

Provider CCN: 26-2010

Period:
From 09/01/2016
To 08/31/2017

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
34.17		0			0.00	0	34.17
34.18		0			0.00	0	34.18
34.19		0			0.00	0	34.19
34.20		0			0.00	0	34.20
34.21		0			0.00	0	34.21
34.22		0			0.00	0	34.22
34.23		0			0.00	0	34.23
34.24		0			0.00	0	34.24
34.25	FRA Tax - Adjust to Actual	A	-10,067	ADMINISTRATIVE & GENERAL	5.00	0	34.25
34.26	OFFSET DEPR OF ASSET TRANSFERRED	A	-32,071	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.26
34.27	Remove non-allowable salary	A	-2,873	RESPIRATORY THERAPY	65.00	0	34.27
34.28	Remove benefits for non-allowable salary	A	-272	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.28
35.00			0		0.00	0	35.00
35.01	PHYSICIAN FEE ADJUSTMENT	A	-3,815	ADMINISTRATIVE & GENERAL	5.00	0	35.01
35.02			0		0.00	0	35.02
35.03			0		0.00	0	35.03
35.04			0		0.00	0	35.04
35.05			0		0.00	0	35.05
35.06			0		0.00	0	35.06
35.07			0		0.00	0	35.07
35.08			0		0.00	0	35.08
35.09	PHYSICIAN FEE ADJUSTMENT	A	4,388	MEDICAL RECORDS & LIBRARY	16.00	0	35.09
35.10			0		0.00	0	35.10
35.11	PHYSICIAN FEE ADJUSTMENT	A	29,568	ADULTS & PEDIATRICS	30.00	0	35.11
35.12			0		0.00	0	35.12
35.13			0		0.00	0	35.13
35.14			0		0.00	0	35.14
35.15			0		0.00	0	35.15
35.16			0		0.00	0	35.16
35.17	PHYSICIAN FEE ADJUSTMENT	A	2,929	RESPIRATORY THERAPY	65.00	0	35.17
35.18			0		0.00	0	35.18
35.19			0		0.00	0	35.19
35.20			0		0.00	0	35.20
35.21	PHYSICIAN FEE ADJUSTMENT	A	-33,069	RENAL DIALYSIS	74.00	0	35.21
35.22			0		0.00	0	35.22
35.23			0		0.00	0	35.23
35.24			0		0.00	0	35.24
35.25			0		0.00	0	35.25
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,219,516				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: 26-2010
 Period: From 09/01/2016 To 08/31/2017
 Worksheet A-8-1
 Date/Time Prepared: 1/22/2018 10:19 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	Home Office Costs	2,438,339	1,764,301 1.00
2.00	0.00			0	0 2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	Workers Comp Premium	236,264	236,264 3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	Liability Insurance	114,627	114,627 4.00
4.01	66.00	PHYSICAL THERAPY	Therapy Services	1,183,937	1,276,521 4.01
5.00	0			3,973,167	3,391,713 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	Related Organization(s) and/or Home Office	
			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	KH01	100.00	Admin & Gen	100.00	6.00
7.00	B	KH01	100.00	Cornerstone	100.00	7.00
8.00	B	KH01	100.00	Cornerstone	100.00	8.00
9.00	B	KH01	100.00	RehabCare	100.00	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: 26-2010

Period:
From 09/01/2016
To 08/31/2017

Worksheet A-8-1

Date/Time Prepared:
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	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	674,038	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
4.01	-92,584	0		4.01
5.00	581,454			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	HomeOffice Cost		6.00
7.00	Worker Comp Ins		7.00
8.00	Liability Insur		8.00
9.00	Therapy Svcs		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: 26-2010

Period:
From 09/01/2016
To 08/31/2017

Worksheet A-8-2

Date/Time Prepared:
1/22/2018 10:19 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	DR. A	76,685	0	76,685	211,500	767	1.00
2.00	74.00	DR. B	219	0	219	211,500	1	2.00
3.00	54.00	DR. C	4,736	4,736	0	271,900	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	54.00	DR. E	68,532	68,532	0	271,900	0	5.00
6.00	30.00	DR. F	5,125	0	5,125	211,500	26	6.00
7.00	65.00	DR. G	825	0	825	211,500	5	7.00
8.00	30.00	DR. H	5,813	0	5,813	211,500	38	8.00
9.00	65.00	DR. I	2,104	2,104	0	211,500	0	9.00
10.00	30.00	DR. J	289,976	289,976	0	211,500	0	10.00
14.00	30.00	DR. N	438,071	0	438,071	211,500	4,381	14.00
15.00	16.00	DR. O	4,388	0	4,388	211,500	23	15.00
16.00	30.00	DR. P	1,711	0	1,711	211,500	9	16.00
17.00	54.00	DR. Q	1,568	0	1,568	271,900	5	17.00
200.00			899,753	365,348	534,405		5,255	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	DR. A	77,991	3,900	0	0	0	1.00
2.00	74.00	DR. B	102	5	0	0	0	2.00
3.00	54.00	DR. C	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	54.00	DR. E	0	0	0	0	0	5.00
6.00	30.00	DR. F	2,644	132	0	0	0	6.00
7.00	65.00	DR. G	508	25	0	0	0	7.00
8.00	30.00	DR. H	3,864	193	0	0	0	8.00
9.00	65.00	DR. I	0	0	0	0	0	9.00
10.00	30.00	DR. J	0	0	0	0	0	10.00
14.00	30.00	DR. N	445,472	22,274	0	0	0	14.00
15.00	16.00	DR. O	2,339	117	0	0	0	15.00
16.00	30.00	DR. P	915	46	0	0	0	16.00
17.00	54.00	DR. Q	654	33	0	0	0	17.00
200.00			534,489	26,725	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	DR. A	0	77,991	0	0		1.00
2.00	74.00	DR. B	0	102	117	117		2.00
3.00	54.00	DR. C	0	0	0	4,736		3.00
4.00	0.00		0	0	0	0		4.00
5.00	54.00	DR. E	0	0	0	68,532		5.00
6.00	30.00	DR. F	0	2,644	2,481	2,481		6.00
7.00	65.00	DR. G	0	508	317	317		7.00
8.00	30.00	DR. H	0	3,864	1,949	1,949		8.00
9.00	65.00	DR. I	0	0	0	2,104		9.00
10.00	30.00	DR. J	0	0	0	289,976		10.00
14.00	30.00	DR. N	0	445,472	0	0		14.00
15.00	16.00	DR. O	0	2,339	2,049	2,049		15.00
16.00	30.00	DR. P	0	915	796	796		16.00
17.00	54.00	DR. Q	0	654	914	914		17.00
200.00			0	534,489	8,623	373,971		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-2010

Period:
From 09/01/2016
To 08/31/2017

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,248,137	2,248,137			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	915,830		915,830		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,050,882	6,392	2,604	2,059,878	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	7,122,328	373,126	152,001	326,347	5.00
7.00 00700	OPERATION OF PLANT	1,020,143	117,273	47,774	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	126,446	48,556	19,781	0	8.00
9.00 00900	HOUSEKEEPING	326,530	34,051	13,871	41,630	9.00
10.00 01000	DIETARY	723,146	76,420	31,131	24,090	10.00
11.00 01100	CAFETERIA	0	28,847	11,751	0	11.00
13.00 01300	NURSING ADMINISTRATION	1,310,762	72,773	29,646	236,365	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	400,171	136,777	55,719	19,608	14.00
15.00 01500	PHARMACY	1,256,859	137,187	55,886	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	531,099	51,097	20,815	79,394	16.00
17.00 01700	SOCIAL SERVICE	859,336	32,330	13,170	151,567	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	8,157,851	928,553	378,269	835,232	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	376,328	7,785	3,172	40,029	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	317,071	33,313	13,571	14,624	54.00
60.00 06000	LABORATORY	497,406	40,730	16,592	14,787	60.00
65.00 06500	RESPIRATORY THERAPY	1,722,099	52,449	21,366	262,870	65.00
66.00 06600	PHYSICAL THERAPY	1,200,330	38,927	15,858	243	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	270,989	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,682,430	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	653,043	31,551	12,853	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00 09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	33,769,216	2,248,137	915,830	2,046,786	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	NONALLOWABLE CLINICAL LIAISON	74,369	0	0	13,092	194.00
194.01 07951	IDLE SPACE	0	0	0	0	194.01
194.02 07952	REGIONAL OFFICE	0	0	0	0	194.02
194.03 07953	DISTRICT OFFICE	0	0	0	0	194.03
194.04 07954	NON MCR CERTIFIED UNIT	0	0	0	0	194.04
194.05 07955	REG NURSG OFFICE	0	0	0	0	194.05
194.06 07956	CONTACT CENTER	0	0	0	0	194.06
194.07 07957	CENTRALIZED ADMINISTRATIONS DEPT	0	0	0	0	194.07
194.08 07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.08
194.09 07958	VISITOR MEALS	0	0	0	0	194.09
194.10 07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.10
194.11 07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	33,843,585	2,248,137	915,830	2,059,878	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-2010

Period:
From 09/01/2016
To 08/31/2017

Worksheet B
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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	7,973,802				5.00
7.00	00700	OPERATION OF PLANT	365,309	1,550,499			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	60,038	42,988	297,809		8.00
9.00	00900	HOUSEKEEPING	128,248	30,146	0	574,476	9.00
10.00	01000	DIETARY	263,469	67,656	0	26,308	1,212,220
11.00	01100	CAFETERIA	12,513	25,539	0	9,931	553,239
13.00	01300	NURSING ADMINISTRATION	508,436	64,427	0	25,053	0
14.00	01400	CENTRAL SERVICES & SUPPLY	188,720	121,091	0	47,087	0
15.00	01500	PHARMACY	446,910	121,454	0	47,228	0
16.00	01600	MEDICAL RECORDS & LIBRARY	210,336	45,237	0	17,590	0
17.00	01700	SOCIAL SERVICE	325,613	28,622	0	11,130	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,174,731	822,064	297,809	319,660	658,981
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	131,710	6,893	0	2,680	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	116,689	29,493	0	11,468	0
60.00	06000	LABORATORY	175,540	36,059	0	14,022	0
65.00	06500	RESPIRATORY THERAPY	634,575	46,434	0	18,056	0
66.00	06600	PHYSICAL THERAPY	386,936	34,463	0	13,401	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	83,526	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	518,572	0	0	0	0
74.00	07400	RENAL DIALYSIS	214,973	27,933	0	10,862	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,946,844	1,550,499	297,809	574,476	1,212,220
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	NONALLOWABLE CLINICAL LIAISON	26,958	0	0	0	0
194.01	07951	IDLE SPACE	0	0	0	0	0
194.02	07952	REGIONAL OFFICE	0	0	0	0	0
194.03	07953	DISTRICT OFFICE	0	0	0	0	0
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0
194.05	07955	REG NURSG OFFICE	0	0	0	0	0
194.06	07956	CONTACT CENTER	0	0	0	0	0
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	0
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0
194.09	07958	VISITOR MEALS	0	0	0	0	0
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	7,973,802	1,550,499	297,809	574,476	1,212,220

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-2010

Period:
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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						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	641,820					11.00
13.00	01300	63,757	2,311,219				13.00
14.00	01400	12,751	0	981,924			14.00
15.00	01500	0	0	18,138	2,083,662		15.00
16.00	01600	29,753	0	1,021	0	986,342	16.00
17.00	01700	46,755	0	3	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	365,541	2,233,313	531,535	3,061	420,739	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	12,751	77,906	0	0	4,611	50.00
54.00	05400	4,250	0	52	0	14,540	54.00
60.00	06000	8,501	0	6,860	0	91,111	60.00
65.00	06500	97,761	0	153,130	0	224,078	65.00
66.00	06600	0	0	11,504	338	44,257	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	0	259,681	0	9,591	71.00
73.00	07300	0	0	0	2,080,263	159,375	73.00
74.00	07400	0	0	0	0	18,040	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
98.00	09850	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		641,820	2,311,219	981,924	2,083,662	986,342	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		641,820	2,311,219	981,924	2,083,662	986,342	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-2010

Period:
From 09/01/2016
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Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	1,468,526			17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,468,526	20,595,865	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	663,865	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	555,071	0	54.00
60.00	06000	LABORATORY	0	901,608	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,232,818	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,746,257	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	623,787	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,440,640	0	73.00
74.00	07400	RENAL DIALYSIS	0	969,255	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,468,526	33,729,166	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	114,419	0	194.00
194.01	07951	IDLE SPACE	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	194.05
194.06	07956	CONTACT CENTER	0	0	0	194.06
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	194.11
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,468,526	33,843,585	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 26-2010	Period: From 09/01/2016 To 08/31/2017	Worksheet B Part II Date/Time Prepared: 1/22/2018 10:19 am
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,392	2,604	8,996	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	229,047	373,126	152,001	754,174	5.00
7.00 00700	OPERATION OF PLANT	0	117,273	47,774	165,047	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	48,556	19,781	68,337	8.00
9.00 00900	HOUSEKEEPING	0	34,051	13,871	47,922	9.00
10.00 01000	DIETARY	0	76,420	31,131	107,551	10.00
11.00 01100	CAFETERIA	0	28,847	11,751	40,598	11.00
13.00 01300	NURSING ADMINISTRATION	0	72,773	29,646	102,419	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	136,777	55,719	192,496	14.00
15.00 01500	PHARMACY	0	137,187	55,886	193,073	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	51,097	20,815	71,912	16.00
17.00 01700	SOCIAL SERVICE	0	32,330	13,170	45,500	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	928,553	378,269	1,306,822	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	7,785	3,172	10,957	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	33,313	13,571	46,884	54.00
60.00 06000	LABORATORY	0	40,730	16,592	57,322	60.00
65.00 06500	RESPIRATORY THERAPY	0	52,449	21,366	73,815	65.00
66.00 06600	PHYSICAL THERAPY	0	38,927	15,858	54,785	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	31,551	12,853	44,404	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00 09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	229,047	2,248,137	915,830	3,393,014	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	NONALLOWABLE CLINICAL LIAISON	0	0	0	0	194.00
194.01 07951	IDLE SPACE	0	0	0	0	194.01
194.02 07952	REGIONAL OFFICE	0	0	0	0	194.02
194.03 07953	DISTRICT OFFICE	0	0	0	0	194.03
194.04 07954	NON MCR CERTIFIED UNIT	0	0	0	0	194.04
194.05 07955	REG NURSG OFFICE	0	0	0	0	194.05
194.06 07956	CONTACT CENTER	0	0	0	0	194.06
194.07 07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	194.07
194.08 07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.08
194.09 07958	VISITOR MEALS	0	0	0	0	194.09
194.10 07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.10
194.11 07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	229,047	2,248,137	915,830	3,393,014	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 26-2010	Period: From 09/01/2016 To 08/31/2017	Worksheet B Part II Date/Time Prepared: 1/22/2018 10:19 am		
Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
			5.00	7.00	8.00	9.00	10.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	755,599				5.00
7.00	00700	OPERATION OF PLANT	34,617	199,664			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,689		79,562		8.00
9.00	00900	HOUSEKEEPING	12,153	3,882	0	64,139	9.00
10.00	01000	DIETARY	24,967	8,712	0	2,937	144,272
11.00	01100	CAFETERIA	1,186	3,289	0	1,109	65,844
13.00	01300	NURSING ADMINISTRATION	48,180	8,297	0	2,797	0
14.00	01400	CENTRAL SERVICES & SUPPLY	17,883	15,593	0	5,257	0
15.00	01500	PHARMACY	42,350	15,640	0	5,273	0
16.00	01600	MEDICAL RECORDS & LIBRARY	19,932	5,825	0	1,964	0
17.00	01700	SOCIAL SERVICE	30,855	3,686	0	1,243	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	300,834	105,860	79,562	35,690	78,428
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	12,481	888	0	299	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,058	3,798	0	1,280	0
60.00	06000	LABORATORY	16,634	4,643	0	1,565	0
65.00	06500	RESPIRATORY THERAPY	60,133	5,980	0	2,016	0
66.00	06600	PHYSICAL THERAPY	36,666	4,438	0	1,496	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,915	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	49,140	0	0	0	0
74.00	07400	RENAL DIALYSIS	20,371	3,597	0	1,213	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	753,044	199,664	79,562	64,139	144,272
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	NONALLOWABLE CLINICAL LIAISON	2,555	0	0	0	0
194.01	07951	IDLE SPACE	0	0	0	0	0
194.02	07952	REGIONAL OFFICE	0	0	0	0	0
194.03	07953	DISTRICT OFFICE	0	0	0	0	0
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0
194.05	07955	REG NURSG OFFICE	0	0	0	0	0
194.06	07956	CONTACT CENTER	0	0	0	0	0
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	0
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0
194.09	07958	VISITOR MEALS	0	0	0	0	0
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	755,599	199,664	79,562	64,139	144,272

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 26-2010	Period: From 09/01/2016 To 08/31/2017	Worksheet B Part II Date/Time Prepared: 1/22/2018 10:19 am
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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						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	112,026					11.00
13.00	01300	11,128	173,853				13.00
14.00	01400	2,226	0	233,541			14.00
15.00	01500	0	0	4,314	260,650		15.00
16.00	01600	5,193	0	243	0	105,416	16.00
17.00	01700	8,161	0	1	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	63,802	167,993	126,421	383	44,977	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	2,226	5,860	0	0	493	50.00
54.00	05400	742	0	12	0	1,554	54.00
60.00	06000	1,484	0	1,632	0	9,736	60.00
65.00	06500	17,064	0	36,420	0	23,944	65.00
66.00	06600	0	0	2,736	42	4,729	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	0	61,762	0	1,025	71.00
73.00	07300	0	0	0	260,225	17,030	73.00
74.00	07400	0	0	0	0	1,928	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
98.00	09850	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		112,026	173,853	233,541	260,650	105,416	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		112,026	173,853	233,541	260,650	105,416	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 26-2010	Period: From 09/01/2016 To 08/31/2017	Worksheet B Part II Date/Time Prepared: 1/22/2018 10:19 am		
Cost Center	Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		17.00	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00	
5.00	00500	ADMINISTRATIVE & GENERAL				5.00	
7.00	00700	OPERATION OF PLANT				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE				8.00	
9.00	00900	HOUSEKEEPING				9.00	
10.00	01000	DIETARY				10.00	
11.00	01100	CAFETERIA				11.00	
13.00	01300	NURSING ADMINISTRATION				13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00	
15.00	01500	PHARMACY				15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00	
17.00	01700	SOCIAL SERVICE	90,108			17.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	90,108	2,404,527	0	2,404,527	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	33,379	0	33,379	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	65,392	0	65,392	54.00
60.00	06000	LABORATORY	0	93,081	0	93,081	60.00
65.00	06500	RESPIRATORY THERAPY	0	220,520	0	220,520	65.00
66.00	06600	PHYSICAL THERAPY	0	104,893	0	104,893	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	70,702	0	70,702	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	326,395	0	326,395	73.00
74.00	07400	RENAL DIALYSIS	0	71,513	0	71,513	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	90,108	3,390,402	0	3,390,402	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	NONALLOWABLE CLINICAL LIAISON	0	2,612	0	2,612	194.00
194.01	07951	IDLE SPACE	0	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	194.05
194.06	07956	CONTACT CENTER	0	0	0	0	194.06
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	90,108	3,393,014	0	3,393,014	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-2010

Period:
From 09/01/2016
To 08/31/2017

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 #1)	MVBLE EQUIP (SQUARE FEET #2)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	54,865				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		54,865			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	156	156	11,078,107		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	9,106	9,106	1,755,108	-7,973,802	5.00
7.00 00700	OPERATION OF PLANT	2,862	2,862	0	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,185	1,185	0	0	8.00
9.00 00900	HOUSEKEEPING	831	831	223,887	0	9.00
10.00 01000	DIETARY	1,865	1,865	129,559	0	10.00
11.00 01100	CAFETERIA	704	704	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	1,776	1,776	1,271,185	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	3,338	3,338	105,452	0	14.00
15.00 01500	PHARMACY	3,348	3,348	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,247	1,247	426,986	0	16.00
17.00 01700	SOCIAL SERVICE	789	789	815,134	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	22,661	22,661	4,491,897	0	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	190	190	215,276	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	813	813	78,649	0	54.00
60.00 06000	LABORATORY	994	994	79,525	0	60.00
65.00 06500	RESPIRATORY THERAPY	1,280	1,280	1,413,729	0	65.00
66.00 06600	PHYSICAL THERAPY	950	950	1,309	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	770	770	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00 09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	54,865	54,865	11,007,696	-7,973,802	25,782,322
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	NONALLOWABLE CLINICAL LIAISON	0	0	70,411	0	87,461
194.01 07951	IDLE SPACE	0	0	0	0	194.01
194.02 07952	REGIONAL OFFICE	0	0	0	0	194.02
194.03 07953	DISTRICT OFFICE	0	0	0	0	194.03
194.04 07954	NON MCR CERTIFIED UNIT	0	0	0	0	194.04
194.05 07955	REG NURSG OFFICE	0	0	0	0	194.05
194.06 07956	CONTACT CENTER	0	0	0	0	194.06
194.07 07957	CENTRALIZED ADMINISTRATIONS DEPT	0	0	0	0	194.07
194.08 07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.08
194.09 07958	VISITOR MEALS	0	0	0	0	194.09
194.10 07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.10
194.11 07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,248,137	915,830	2,059,878		7,973,802
203.00	Unit cost multiplier (Wkst. B, Part I)	40.975795	16.692427	0.185941		0.308228
204.00	Cost to be allocated (per Wkst. B, Part II)			8,996		755,599
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000812		0.029208

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-2010

Period:
From 09/01/2016
To 08/31/2017

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		OPERATION OF PLANT (SQUARE FEET #3)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET #4)	DIETARY (MEALS SERVED)	CAFETERIA (CAFETERIA FTES)	
		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	42,741				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,185	20,213			8.00
9.00	00900	HOUSEKEEPING	831	0	40,725		9.00
10.00	01000	DIETARY	1,865	0	1,865	34,105	10.00
11.00	01100	CAFETERIA	704	0	704	15,565	151
13.00	01300	NURSING ADMINISTRATION	1,776	0	1,776	0	15
14.00	01400	CENTRAL SERVICES & SUPPLY	3,338	0	3,338	0	3
15.00	01500	PHARMACY	3,348	0	3,348	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	1,247	0	1,247	0	7
17.00	01700	SOCIAL SERVICE	789	0	789	0	11
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	22,661	20,213	22,661	18,540	86
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	190	0	190	0	3
54.00	05400	RADIOLOGY-DIAGNOSTIC	813	0	813	0	1
60.00	06000	LABORATORY	994	0	994	0	2
65.00	06500	RESPIRATORY THERAPY	1,280	0	1,280	0	23
66.00	06600	PHYSICAL THERAPY	950	0	950	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	770	0	770	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	42,741	20,213	40,725	34,105	151
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	0	0	0	0
194.01	07951	IDLE SPACE	0	0	0	0	0
194.02	07952	REGIONAL OFFICE	0	0	0	0	0
194.03	07953	DISTRICT OFFICE	0	0	0	0	0
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0
194.05	07955	REG NURSG OFFICE	0	0	0	0	0
194.06	07956	CONTACT CENTER	0	0	0	0	0
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	0
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0
194.09	07958	VISITOR MEALS	0	0	0	0	0
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0
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)	1,550,499	297,809	574,476	1,212,220	641,820
203.00		Unit cost multiplier (Wkst. B, Part I)	36.276620	14.733538	14.106225	35.543762	4,250.463576
204.00		Cost to be allocated (per Wkst. B, Part II)	199,664	79,562	64,139	144,272	112,026
205.00		Unit cost multiplier (Wkst. B, Part II)	4.671486	3.936180	1.574929	4.230230	741.894040

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-2010

Period:
From 09/01/2016
To 08/31/2017

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Date/Time Prepared:
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Cost Center Description		NURSING ADMINISTRATION (NURSING FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	89					13.00
14.00	01400	0	1,024,696				14.00
15.00	01500	0	18,928	1,685,179			15.00
16.00	01600	0	1,065	0	135,826,308		16.00
17.00	01700	0	3	0	0	20,213	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	86	554,690	2,476	57,940,999	20,213	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	3	0	0	634,945	0	50.00
54.00	05400	0	54	0	2,002,194	0	54.00
60.00	06000	0	7,159	0	12,546,212	0	60.00
65.00	06500	0	159,800	0	30,856,296	0	65.00
66.00	06600	0	12,005	273	6,094,321	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	270,992	0	1,320,651	0	71.00
73.00	07300	0	0	1,682,430	21,946,477	0	73.00
74.00	07400	0	0	0	2,484,213	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
98.00	09850	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		89	1,024,696	1,685,179	135,826,308	20,213	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
200.00							200.00
201.00							201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,311,219	981,924	2,083,662	986,342	1,468,526	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	25,968.752809	0.958259	1.236463	0.007262	72.652550	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	173,853	233,541	260,650	105,416	90,108	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1,953.404494	0.227912	0.154672	0.000776	4.457923	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-2010

Period:
From 09/01/2016
To 08/31/2017

Worksheet C
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Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					RCE Disallowance	Total Costs	
1.00	2.00	3.00	4.00	5.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	20,595,865		20,595,865	5,226	20,601,091	30.00
31.00	03100 INTENSIVE CARE UNIT	0		0	0	0	31.00
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	663,865		663,865	0	663,865	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	555,071		555,071	914	555,985	54.00
60.00	06000 LABORATORY	901,608		901,608	0	901,608	60.00
65.00	06500 RESPIRATORY THERAPY	3,232,818	0	3,232,818	317	3,233,135	65.00
66.00	06600 PHYSICAL THERAPY	1,746,257	0	1,746,257	0	1,746,257	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
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	623,787		623,787	0	623,787	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4,440,640		4,440,640	0	4,440,640	73.00
74.00	07400 RENAL DIALYSIS	969,255		969,255	117	969,372	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0		0	0	0	90.00
91.00	09100 EMERGENCY	0		0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0		0	0	0	95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
200.00	Subtotal (see instructions)	33,729,166	0	33,729,166	6,574	33,735,740	200.00
201.00	Less Observation Beds	0		0	0	0	201.00
202.00	Total (see instructions)	33,729,166	0	33,729,166	6,574	33,735,740	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-2010

Period:
From 09/01/2016
To 08/31/2017

Worksheet C
Part I
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Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	57,940,999		57,940,999		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	634,945	0	634,945	1.045547	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,002,194	0	2,002,194	0.277231	54.00
60.00	06000	LABORATORY	12,546,212	0	12,546,212	0.071863	60.00
65.00	06500	RESPIRATORY THERAPY	30,856,296	0	30,856,296	0.104770	65.00
66.00	06600	PHYSICAL THERAPY	6,094,321	0	6,094,321	0.286538	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,320,651	0	1,320,651	0.472333	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,946,477	0	21,946,477	0.202340	73.00
74.00	07400	RENAL DIALYSIS	2,484,213	0	2,484,213	0.390166	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	98.00
200.00		Subtotal (see instructions)	135,826,308	0	135,826,308		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	135,826,308	0	135,826,308		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 26-2010	Period: From 09/01/2016 To 08/31/2017	Worksheet C Part I Date/Time Prepared: 1/22/2018 10:19 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
44.00	04400 SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	1.045547		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.277688		54.00
60.00	06000 LABORATORY	0.071863		60.00
65.00	06500 RESPIRATORY THERAPY	0.104780		65.00
66.00	06600 PHYSICAL THERAPY	0.286538		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.472333		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.202340		73.00
74.00	07400 RENAL DIALYSIS	0.390213		74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-2010

Period:
From 09/01/2016
To 08/31/2017

Worksheet C
Part I
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		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	20,595,865		20,595,865	5,226	20,601,091	30.00
31.00	03100 INTENSIVE CARE UNIT	0		0	0	0	31.00
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	663,865		663,865	0	663,865	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	555,071		555,071	914	555,985	54.00
60.00	06000 LABORATORY	901,608		901,608	0	901,608	60.00
65.00	06500 RESPIRATORY THERAPY	3,232,818	0	3,232,818	317	3,233,135	65.00
66.00	06600 PHYSICAL THERAPY	1,746,257	0	1,746,257	0	1,746,257	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
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	623,787		623,787	0	623,787	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4,440,640		4,440,640	0	4,440,640	73.00
74.00	07400 RENAL DIALYSIS	969,255		969,255	117	969,372	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0		0	0	0	90.00
91.00	09100 EMERGENCY	0		0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0		0	0	0	95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
200.00	Subtotal (see instructions)	33,729,166	0	33,729,166	6,574	33,735,740	200.00
201.00	Less Observation Beds	0		0	0	0	201.00
202.00	Total (see instructions)	33,729,166	0	33,729,166	6,574	33,735,740	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-2010

Period:
From 09/01/2016
To 08/31/2017

Worksheet C
Part I
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		Title XIX			Hospital	Cost		
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
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	57,940,999		57,940,999			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	634,945	0	634,945	1.045547	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,002,194	0	2,002,194	0.277231	0.000000	54.00
60.00	06000	LABORATORY	12,546,212	0	12,546,212	0.071863	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	30,856,296	0	30,856,296	0.104770	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	6,094,321	0	6,094,321	0.286538	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,320,651	0	1,320,651	0.472333	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,946,477	0	21,946,477	0.202340	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,484,213	0	2,484,213	0.390166	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
200.00		Subtotal (see instructions)	135,826,308	0	135,826,308			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	135,826,308	0	135,826,308			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 26-2010	Period: From 09/01/2016 To 08/31/2017	Worksheet C Part I Date/Time Prepared: 1/22/2018 10:19 am
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
44.00	04400 SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
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: 26-2010		Period: From 09/01/2016 To 08/31/2017		Worksheet D Part I Date/Time Prepared: 1/22/2018 10:19 am	
		Title XVIII		Hospital		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,404,527	0	2,404,527	20,213	118.96	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (Lines 30-199)	2,404,527		2,404,527	20,213		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	11,182	1,330,211				
31.00	INTENSIVE CARE UNIT	0	0				
44.00	SKILLED NURSING FACILITY	0	0				
200.00	Total (Lines 30-199)	11,182	1,330,211				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 26-2010	Period: From 09/01/2016 To 08/31/2017	Worksheet D Part II Date/Time Prepared: 1/22/2018 10:19 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	33,379	634,945	0.052570	337,262	17,730	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	65,392	2,002,194	0.032660	1,205,963	39,387	54.00
60.00	06000 LABORATORY	93,081	12,546,212	0.007419	7,571,418	56,172	60.00
65.00	06500 RESPIRATORY THERAPY	220,520	30,856,296	0.007147	15,758,372	112,625	65.00
66.00	06600 PHYSICAL THERAPY	104,893	6,094,321	0.017212	3,549,097	61,087	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	70,702	1,320,651	0.053536	686,310	36,742	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	326,395	21,946,477	0.014872	12,519,098	186,184	73.00
74.00	07400 RENAL DIALYSIS	71,513	2,484,213	0.028787	1,215,673	34,996	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0	0	0.000000	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00	Total (Lines 50-199)	985,875	77,885,309		42,843,193	544,923	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 26-2010		Period: From 09/01/2016 To 08/31/2017		Worksheet D Part III Date/Time Prepared: 1/22/2018 10:19 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	20,213	0.00	11,182	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0.00	0	0		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0		44.00
200.00		Total (lines 30-199)	20,213		11,182	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-2010

Period:
From 09/01/2016
To 08/31/2017

Worksheet D
Part IV
Date/Time Prepared:
1/22/2018 10:19 am

Cost Center Description		Title XVIII			Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
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
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
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 26-2010	Period: From 09/01/2016 To 08/31/2017	Worksheet D Part IV Date/Time Prepared: 1/22/2018 10:19 am
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	634,945	0.000000	0.000000	337,262	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	2,002,194	0.000000	0.000000	1,205,963	54.00
60.00	06000 LABORATORY	0	12,546,212	0.000000	0.000000	7,571,418	60.00
65.00	06500 RESPIRATORY THERAPY	0	30,856,296	0.000000	0.000000	15,758,372	65.00
66.00	06600 PHYSICAL THERAPY	0	6,094,321	0.000000	0.000000	3,549,097	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,320,651	0.000000	0.000000	686,310	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	21,946,477	0.000000	0.000000	12,519,098	73.00
74.00	07400 RENAL DIALYSIS	0	2,484,213	0.000000	0.000000	1,215,673	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	0	0.000000	0.000000	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0.000000	0	95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0.000000	0	98.00
200.00	Total (Lines 50-199)	0	77,885,309			42,843,193	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 26-2010	Period: From 09/01/2016 To 08/31/2017	Worksheet D Part IV Date/Time Prepared: 1/22/2018 10:19 am
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
Title XVIII Hospital PPS						
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000 LABORATORY	0	0	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0		91.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	0	0		95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
200.00	Total (Lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 26-2010	Period: From 09/01/2016 To 08/31/2017	Worksheet D Part V Date/Time Prepared: 1/22/2018 10:19 am
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Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see inst.)	Charges Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs PPS Services (see inst.)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1.045547	0	0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.277231	0	43,417	0	0	54.00
60.00	06000 LABORATORY	0.071863	0	780	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.104770	0	195,211	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.286538	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.472333	0	5,295	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.202340	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.390166	0	208,475	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0.000000		0			95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00	Subtotal (see instructions)		0	453,178	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	453,178	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 26-2010	Period: From 09/01/2016 To 08/31/2017	Worksheet D Part V Date/Time Prepared: 1/22/2018 10:19 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	12,037	0	54.00
60.00	06000 LABORATORY	56	0	60.00
65.00	06500 RESPIRATORY THERAPY	20,452	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
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,501	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	81,340	0	74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0		95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	98.00
200.00	Subtotal (see instructions)	116,386	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	116,386	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-2010	Period: From 09/01/2016 To 08/31/2017	Worksheet D-1 Date/Time Prepared: 1/22/2018 10:19 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		20,213	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		20,213	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)		20,213	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)		11,182	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)		20,601,091	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)		20,601,091	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)		20,601,091	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,019.20	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		11,396,694	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)		11,396,694	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 26-2010	Period: From 09/01/2016 To 08/31/2017	Worksheet D-1 Date/Time Prepared: 1/22/2018 10:19 am
Title XVIII			Hospital		PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					7,231,374 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					18,628,068 49.00
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,330,211 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					544,923 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,875,134 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					16,752,934 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0 54.00
55.00 Target amount per discharge					0.00 55.00
56.00 Target amount (line 54 x line 55)					0 56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00 Bonus payment (see instructions)					0 58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00 Relief payment (see instructions)					0 62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					0 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-2010		Period: From 09/01/2016 To 08/31/2017		Worksheet D-1 Date/Time Prepared: 1/22/2018 10:19 am	
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)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,404,527	20,601,091	0.116718	0	0	90.00
91.00	Nursing School cost	0	20,601,091	0.000000	0	0	91.00
92.00	Allied health cost	0	20,601,091	0.000000	0	0	92.00
93.00	All other Medical Education	0	20,601,091	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-2010	Period: From 09/01/2016 To 08/31/2017	Worksheet D-1 Date/Time Prepared: 1/22/2018 10:19 am
Cost Center Description		Title XIX	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		20,213	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		20,213	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)		20,213	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,559	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)		20,595,865	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)		20,595,865	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)		20,595,865	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,018.94	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,607,467	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,607,467	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 26-2010	Period: From 09/01/2016 To 08/31/2017	Worksheet D-1 Date/Time Prepared: 1/22/2018 10:19 am
Title XIX			Hospital		Cost
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0 43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,607,467 49.00
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0 54.00
55.00 Target amount per discharge					0.00 55.00
56.00 Target amount (line 54 x line 55)					0 56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00 Bonus payment (see instructions)					0 58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00 Relief payment (see instructions)					0 62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					0 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-2010		Period: From 09/01/2016 To 08/31/2017		Worksheet D-1 Date/Time Prepared: 1/22/2018 10:19 am	
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	2,404,527	20,595,865	0.116748	0	0	90.00
91.00	Nursing School cost	0	20,595,865	0.000000	0	0	91.00
92.00	Allied health cost	0	20,595,865	0.000000	0	0	92.00
93.00	All other Medical Education	0	20,595,865	0.000000	0	0	93.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 26-2010

Period:
From 09/01/2016
To 08/31/2017

Worksheet D-2
Date/Time Prepared:
1/22/2018 10:19 am

Cost Center Description	Percent of Assigned Time	Expense Allocation	Total Inpatient Day All Patients	Average Cost Per Day	Health Care Program Inpatient Days Title V															
	1.00	2.00	3.00	4.00	5.00															
PART I - NOT IN APPROVED TEACHING PROGRAM																				
Hospital Inpatient Routine Services:																				
1.00 Total cost of services rendered	0.00	0				1.00														
2.00 ADULTS & PEDIATRICS	0.00	0	20,213	0.00	0	2.00														
3.00 INTENSIVE CARE UNIT	0.00	0	0	0.00	0	3.00														
4.00 CORONARY CARE UNIT						4.00														
5.00 BURN INTENSIVE CARE UNIT						5.00														
6.00 SURGICAL INTENSIVE CARE UNIT						6.00														
7.00 OTHER SPECIAL CARE (SPECIFY)						7.00														
8.00 NURSERY						8.00														
9.00 Subtotal (sum of lines 2 through 8)	0.00	0				9.00														
10.00 SUBPROVIDER - IPF						10.00														
11.00 SUBPROVIDER - IRF						11.00														
12.00 SUBPROVIDER						12.00														
13.00 SKILLED NURSING FACILITY	0.00	0	0	0.00	0	13.00														
14.00 NURSING FACILITY						14.00														
15.00 OTHER LONG TERM CARE						15.00														
16.00 HOME HEALTH AGENCY						16.00														
17.00 CMHC						17.00														
18.00 AMBULATORY SURGICAL CENTER (D.P.)						18.00														
19.00 HOSPICE						19.00														
20.00 Subtotal (sum of lines 9 through 19)	0.00	0				20.00														
<table border="1"> <thead> <tr> <th>Cost Center Description</th> <th></th> <th></th> <th>Total Charges (from Worksheet C, Part I, column 8, lines 88 through 93)</th> <th>Ratio of Cost to Charges (col. 2 ÷ col. 3)</th> <th>Titles V and XIX Outpatient and Title XVIII Part B Charges Title V</th> <th></th> </tr> <tr> <td></td> <td>1.00</td> <td>2.00</td> <td>3.00</td> <td>4.00</td> <td>5.00</td> <td></td> </tr> </thead> </table>							Cost Center Description			Total Charges (from Worksheet C, Part I, column 8, lines 88 through 93)	Ratio of Cost to Charges (col. 2 ÷ col. 3)	Titles V and XIX Outpatient and Title XVIII Part B Charges Title V			1.00	2.00	3.00	4.00	5.00	
Cost Center Description			Total Charges (from Worksheet C, Part I, column 8, lines 88 through 93)	Ratio of Cost to Charges (col. 2 ÷ col. 3)	Titles V and XIX Outpatient and Title XVIII Part B Charges Title V															
	1.00	2.00	3.00	4.00	5.00															
Hospital Outpatient Services:																				
21.00 RURAL HEALTH CLINIC						21.00														
22.00 FEDERALLY QUALIFIED HEALTH CENTER CLINIC	0.00	0	0	0.000000	0	22.00														
23.00 EMERGENCY	0.00	0	0	0.000000	0	23.00														
24.00 OBSERVATION BEDS (NON-DISTINCT PART)						24.00														
25.00 OTHER OUTPATIENT SERVICE COST CENTER						25.00														
26.00 Subtotal (sum of lines 21 through 26)	0.00	0				26.00														
27.00 Total (sum of lines 20 and 27)	0.00	0				27.00														
28.00						28.00														
<table border="1"> <thead> <tr> <th>Cost Center Description</th> <th>Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22</th> <th>Swing bed Amount</th> <th>Net cost (column 1 plus column 2)</th> <th>Total Inpatient Days - All Patients</th> <th>Average Cost Per Day (col. 3 ÷ col. 4)</th> <th></th> </tr> <tr> <td></td> <td>1.00</td> <td>2.00</td> <td>3.00</td> <td>4.00</td> <td>5.00</td> <td></td> </tr> </thead> </table>							Cost Center Description	Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22	Swing bed Amount	Net cost (column 1 plus column 2)	Total Inpatient Days - All Patients	Average Cost Per Day (col. 3 ÷ col. 4)			1.00	2.00	3.00	4.00	5.00	
Cost Center Description	Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22	Swing bed Amount	Net cost (column 1 plus column 2)	Total Inpatient Days - All Patients	Average Cost Per Day (col. 3 ÷ col. 4)															
	1.00	2.00	3.00	4.00	5.00															
PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)																				
Hospital Inpatient Routine Services:																				
29.00 ADULTS & PEDIATRICS	0	0	0	20,213	0.00	29.00														
30.00 Swing Bed - SNF				0	0.00	30.00														
31.00 Swing Bed - NF				0		31.00														
32.00 INTENSIVE CARE UNIT	0			0	0.00	32.00														
33.00 CORONARY CARE UNIT						33.00														
34.00 BURN INTENSIVE CARE UNIT						34.00														
35.00 SURGICAL INTENSIVE CARE UNIT						35.00														
36.00 OTHER SPECIAL CARE (SPECIFY)						36.00														
37.00 Subtotal (sum of lines 29, and 32 through 36)	0			0		37.00														
38.00 SUBPROVIDER - IPF						38.00														
39.00 SUBPROVIDER - IRF						39.00														
40.00 SUBPROVIDER						40.00														
41.00 SKILLED NURSING FACILITY	0			0	0.00	41.00														
42.00 Total (sum of lines 37 through 41)	0			0		42.00														

Cost Center Description	Not In Approved Teaching Program		In Approved Teaching Program	
	(from Part I:)	Amount	(from Part II, col. 7, -)	
	1.00	2.00	3.00	
PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED)				
Hospital				
43.00 Inpatient	col. 9, line 9.00		0 line 37.00	43.00
44.00 Outpatient	col. 9, line 27.00		0	44.00
45.00 Total Hospital (sum of lines 43 and 44)			0	45.00
46.00 SUBPROVIDER - IPF				46.00
47.00 SUBPROVIDER - IRF				47.00
48.00 SUBPROVIDER				48.00
49.00 SKILLED NURSING FACILITY	col. 9, line 13.00		0 col. 9, line 41.00	49.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS	Provider CCN: 26-2010	Period: From 09/01/2016 To 08/31/2017	Worksheet D-2 Date/Time Prepared: 1/22/2018 10:19 am
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Cost Center Description	Health Care Program Inpatient Days		Title V (col. 4 x col. 5)	Title XVIII (col. 4 x col. 6)	Title XIX (col. 4 x col. 7)	
	Title XVIII, Part B Only Less Part A Coverage but no Part B Coverage	Title XIX				
	6.00	7.00				
PART I - NOT IN APPROVED TEACHING PROGRAM						
1.00 Total cost of services rendered						1.00
Hospital Inpatient Routine Services:						
2.00 ADULTS & PEDIATRICS	11,182	2,559	0	0	0	2.00
3.00 INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00 CORONARY CARE UNIT						4.00
5.00 BURN INTENSIVE CARE UNIT						5.00
6.00 SURGICAL INTENSIVE CARE UNIT						6.00
7.00 OTHER SPECIAL CARE (SPECIFY)						7.00
8.00 NURSERY						8.00
9.00 Subtotal (sum of lines 2 through 8)			0	0	0	9.00
10.00 SUBPROVIDER - IPF						10.00
11.00 SUBPROVIDER - IRF						11.00
12.00 SUBPROVIDER						12.00
13.00 SKILLED NURSING FACILITY	0	0	0	0	0	13.00
14.00 NURSING FACILITY						14.00
15.00 OTHER LONG TERM CARE						15.00
16.00 HOME HEALTH AGENCY						16.00
17.00 CMHC						17.00
18.00 AMBULATORY SURGICAL CENTER (D.P.)						18.00
19.00 HOSPICE						19.00
20.00 Subtotal (sum of lines 9 through 19)						20.00
Cost Center Description		Titles V and XIX Outpatient and Title XVIII Part B Charges		Titles V and XIX Outpatient and Title XVIII Part B Cost		
		Title XVIII Part B	Title XIX	Title V	Title XVIII Part B	Title XIX
		6.00	7.00	8.00	9.00	10.00
Hospital Outpatient Services:						
21.00 RURAL HEALTH CLINIC						21.00
22.00 FEDERALLY QUALIFIED HEALTH CENTER						22.00
23.00 CLINIC	0	0	0	0	0	23.00
24.00 EMERGENCY	0	0	0	0	0	24.00
25.00 OBSERVATION BEDS (NON-DISTINCT PART)						25.00
26.00 OTHER OUTPATIENT SERVICE COST CENTER						26.00
27.00 Subtotal (sum of lines 21 through 26)			0	0	0	27.00
28.00 Total (sum of lines 20 and 27)						28.00
Cost Center Description		Title XVIII Part B Inpatient Days	Expenses Applicable to Title XVIII (col. 5 x col. 6)	PSA Adj. Interns & Residents		
		6.00	7.00	11.00		
PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)						
Hospital Inpatient Routine Services:						
29.00 ADULTS & PEDIATRICS	0	0	0			29.00
30.00 Swing Bed - SNF	0	0				30.00
31.00 Swing Bed - NF						31.00
32.00 INTENSIVE CARE UNIT	0	0	0			32.00
33.00 CORONARY CARE UNIT						33.00
34.00 BURN INTENSIVE CARE UNIT						34.00
35.00 SURGICAL INTENSIVE CARE UNIT						35.00
36.00 OTHER SPECIAL CARE (SPECIFY)						36.00
37.00 Subtotal (sum of lines 29, and 32 through 36)		0	0			37.00
38.00 SUBPROVIDER - IPF						38.00
39.00 SUBPROVIDER - IRF						39.00
40.00 SUBPROVIDER						40.00
41.00 SKILLED NURSING FACILITY	0	0	0			41.00
42.00 Total (sum of lines 37 through 41)		0	0			42.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 26-2010

Period:
From 09/01/2016
To 08/31/2017

Worksheet D-2

Date/Time Prepared:
1/22/2018 10:19 am

Cost Center Description	In Approved Teaching Program	Total Title XVIII Costs			
	Amount	(to Wkst. E, Part B -)	(col. 2 + col. 4)		
	4.00	5.00	6.00		
PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED)					
Hospital					
43.00	Inpatient	0		0	43.00
44.00	Outpatient				44.00
45.00	Total Hospital (sum of lines 43 and 44)	0	line 22	0	45.00
46.00	SUBPROVIDER - IPF				46.00
47.00	SUBPROVIDER - IRF				47.00
48.00	SUBPROVIDER				48.00
49.00	SKILLED NURSING FACILITY	0	line 22	0	49.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 26-2010	Period: From 09/01/2016 To 08/31/2017	Worksheet D-3 Date/Time Prepared: 1/22/2018 10:19 am	
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		31,665,602		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	1.045547	337,262	352,623	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.277688	1,205,963	334,881	54.00
60.00	06000 LABORATORY	0.071863	7,571,418	544,105	60.00
65.00	06500 RESPIRATORY THERAPY	0.104780	15,758,372	1,651,162	65.00
66.00	06600 PHYSICAL THERAPY	0.286538	3,549,097	1,016,951	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.472333	686,310	324,167	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.202340	12,519,098	2,533,114	73.00
74.00	07400 RENAL DIALYSIS	0.390213	1,215,673	474,371	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	91.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		42,843,193	7,231,374	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)		42,843,193		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-2010	Period: From 09/01/2016 To 08/31/2017	Worksheet E Part B Date/Time Prepared: 1/22/2018 10:19 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		116,386	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
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 line 3 plus line 4 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)		116,386	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		453,178	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)		453,178	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 charge basis 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)		453,178	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		336,792	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 (line 11 minus line 20) (for CAH see instructions)		116,386	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, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		90,636	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		0	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)		25,750	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)		25,750	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		25,750	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		25,750	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		25,750	40.00
40.01	Sequestration adjustment (see instructions)		515	40.01
41.00	Interim payments		21,924	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		3,311	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 26-2010		Period: From 09/01/2016 To 08/31/2017		Worksheet E-1 Part I Date/Time Prepared: 1/22/2018 10:19 am	
		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		15,836,687		21,924	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	05/17/2017	233,400		0	3.01	
3.02		11/30/2017	399,900		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	03/23/2017	1,300,000		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-666,700		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		15,169,987		21,924	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		10,877		3,311	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		15,180,864		25,235	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		Provider CCN: 26-2010	Period: From 09/01/2016 To 08/31/2017	Worksheet E-3 Part IV Date/Time Prepared: 1/22/2018 10:19 am
		Title XVIII	Hospital	PPS
		1.00		
PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)		14,425,644	1.00
1.01	Full standard payment amount		10,696,525	1.01
1.02	Short stay outlier standard payment amount		3,121,312	1.02
1.03	Site neutral payment amount - Cost		32,115	1.03
1.04	Site neutral payment amount - IPPS comparable		575,692	1.04
2.00	Outlier Payments		2,119,506	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)		16,545,150	3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)		0	4.00
5.00	Organ acquisition (DO NOT USE THIS LINE)		0	5.00
6.00	Cost of physicians' services in a teaching hospital (see instructions)		0	6.00
7.00	Subtotal (see instructions)		16,545,150	7.00
8.00	Primary payer payments		0	8.00
9.00	Subtotal (line 7 less line 8)		16,545,150	9.00
10.00	Deductibles		27,328	10.00
11.00	Subtotal (line 9 minus line 10)		16,517,822	11.00
12.00	Coinsurance		1,570,177	12.00
13.00	Subtotal (line 11 minus line 12)		14,947,645	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		835,436	14.00
15.00	Adjusted reimbursable bad debts (see instructions)		543,033	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		754,230	16.00
17.00	Subtotal (sum of lines 13 and 15)		15,490,678	17.00
18.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	18.00
19.00	Other pass through costs (see instructions)		0	19.00
20.00	Outlier payments reconciliation		0	20.00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	21.00
21.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	21.50
21.99	Recovery of Accelerated Depreciation		0	21.99
22.00	Total amount payable to the provider (see instructions)		15,490,678	22.00
22.01	Sequestration adjustment (see instructions)		309,814	22.01
23.00	Interim payments		15,169,987	23.00
24.00	Tentative settlement (for contractor use only)		0	24.00
25.00	Balance due provider/program (line 22 minus lines 22.01, 23 and 24)		10,877	25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	26.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions)		2,119,506	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money (see instructions)		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-2010	Period: From 09/01/2016 To 08/31/2017	Worksheet E-3 Part VII Date/Time Prepared: 1/22/2018 10:19 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		2,607,467		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		2,607,467	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		2,607,467	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		2,607,467	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		2,607,467	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS		0	0	37.00
37.01	OTHER ADJUSTMENTS		0	0	37.01
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0		41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 26-2010

Period:
From 09/01/2016
To 08/31/2017

Worksheet G

Date/Time Prepared:
1/22/2018 10:19 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	96,517	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,300,632	0	0	0	4.00
5.00	Other receivable	3,572	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-905,353	0	0	0	6.00
7.00	Inventory	345,244	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	5,840,612	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	3,453,780	0	0	0	17.00
18.00	Accumulated depreciation	-1,691,103	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	5,852,802	0	0	0	23.00
24.00	Accumulated depreciation	-4,341,169	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)	3,274,310	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	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)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	9,114,922	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,180,576	0	0	0	37.00
38.00	Salaries, wages, and fees payable	748,590	0	0	0	38.00
39.00	Payroll taxes payable	10,858	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	0	0	0	0	43.00
44.00	Other current liabilities	1,389,403	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,329,427	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	-26,984,732	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-26,984,732	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-23,655,305	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	32,770,227	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)	32,770,227	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	9,114,922	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 26-2010

Period:
From 09/01/2016
To 08/31/2017

Worksheet G-1

Date/Time Prepared:
1/22/2018 10:19 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		34,751,759		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-1,981,532			2.00
3.00	Total (sum of line 1 and line 2)		32,770,227		0	3.00
4.00	Additions (credit adjustments)	0		0		4.00
5.00	INTERCOMPANY TRANSFERS\ROUNDING	0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		32,770,227		0	11.00
12.00	Deductions (debit adjustments)	0		0		12.00
13.00	INTERCOMPANY TRANSFERS\ROUNDING	0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		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)		32,770,227		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments)		0			4.00
5.00	INTERCOMPANY TRANSFERS\ROUNDING		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)		0			12.00
13.00	INTERCOMPANY TRANSFERS\ROUNDING		0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 26-2010

Period:
From 09/01/2016
To 08/31/2017

Worksheet G-2
Parts I & II
Date/Time Prepared:
1/22/2018 10:19 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	57,940,999		57,940,999	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)	57,940,999		57,940,999	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	57,940,999		57,940,999	17.00
18.00	Ancillary services	77,885,309	0	77,885,309	18.00
19.00	Outpatient services	0	0	0	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				22.00
23.00	AMBULANCE SERVICES	0	0	0	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)	135,826,308	0	135,826,308	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		35,063,101		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)		35,063,101		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 26-2010

Period:
From 09/01/2016
To 08/31/2017

Worksheet G-3

Date/Time Prepared:
1/22/2018 10:19 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	135,826,308	1.00
2.00	Less contractual allowances and discounts on patients' accounts	102,832,171	2.00
3.00	Net patient revenues (line 1 minus line 2)	32,994,137	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	35,063,101	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,068,964	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	8,102	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	127	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	2,988	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	1,735	21.00
22.00	Rental of hospital space	1,081	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	73,399	24.00
25.00	Total other income (sum of lines 6-24)	87,432	25.00
26.00	Total (line 5 plus line 25)	-1,981,532	26.00
27.00	OTHER EXPENSES	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,981,532	29.00