

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: 26-3304	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/24/2018 5:07 pm
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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: 5/24/2018 Time: 5:07 pm

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SHC-ST LOUIS (26-3304) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

VICE PRESIDENT FINANCE

 Title

 Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	0	0	0	508,238	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
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
8.00 NURSING FACILITY	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	0	0	0	508,238	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: 26-3304		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part I Date/Time Prepared: 5/23/2018 6:13 pm			
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 4400 CLAYTON AVENUE			PO Box:							1.00
2.00	City: ST. LOUIS			State: MO		Zip Code: 63110		County:			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	
		V		XVIII		XIX					
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		SHC-ST LOUIS	263304	41180	7	03/02/2011	N	T	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
17.10	Hospital-Based (CORF) I										17.10
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2017	12/31/2017		20.00	
21.00	Type of Control (see instructions)						2			21.00	
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						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.						1	N		23.00	
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	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 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.			0	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-3304	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/23/2018 6:13 pm			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1					26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1					27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0					35.00
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.						36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0					37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)						37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.						38.00
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N				39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N				40.00
		V	XVIII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N			45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N			46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.	N	N	N			47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N			48.00
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	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
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	N					60.00
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03

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	Y/N	IME	Direct GME	IME	Direct GME			
	1.00	2.00	3.00	4.00	5.00			
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04	
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06	
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
	1.00		2.00	3.00	4.00			
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						61.10	0.00 0.00
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						61.20	0.00 0.00
							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)						62.00	0.00
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) Teaching Hospitals that Claim Residents in Nonprovider Settings						62.01	0.00
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)						63.00	N
	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)						64.00	0.00 0.00 0.000000

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet S-2
Part I
Date/Time Prepared:
5/23/2018 6:13 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))			
		1.00	2.00	3.00	4.00	5.00			
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00		
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))			
				1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010									
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00		
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))			
		1.00	2.00	3.00	4.00	5.00			
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00		
						1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.					N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)							0	71.00
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.					N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)							0	76.00

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				1.00	
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N	80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N	81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		Y	85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				109.00
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.		N	110.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-3304	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/23/2018 6:13 pm	
		1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
		1.00	2.00	3.00	
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1	1		118.01
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		HB0180	140.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 26-3304		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part II Date/Time Prepared: 5/23/2018 6:13 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		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	C	05/01/2018			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.	Y					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	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.				N		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.				N		15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N			N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	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: 26-3304	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/23/2018 6:13 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	NONE	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.	Y	Y		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			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		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.	DOUGLAS	BEAL		41.00
42.00	Enter the employer/company name of the cost report preparer.	SHRI NERS HOSPITALS FOR CHILDREN			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	813.281.8610	DBEAL@SHRI NENET.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 26-3304	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/23/2018 6:13 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CORPORATE REIMBURSEMENT DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet S-3
Part I
Date/Time Prepared:
5/23/2018 6:13 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Trips	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	12	4,380	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)		12	4,380	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00 CORONARY CARE UNIT	32.00	0	0	0.00	0	9.00
10.00 BURN INTENSIVE CARE UNIT	33.00	0	0	0.00	0	10.00
11.00 SURGICAL INTENSIVE CARE UNIT	34.00	0	0	0.00	0	11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		12	4,380	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00 NURSING FACILITY	45.00	0	0		0	20.00
21.00 OTHER LONG TERM CARE	46.00	0	0		0	21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)	115.00					23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC	99.00				0	25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		12				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet S-3
Part I
Date/Time Prepared:
5/23/2018 6:13 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents			
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll		
	6.00	7.00	8.00	9.00	10.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	0	66	1,301			1.00
2.00	HMO and other (see instructions)	0	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	66	1,301			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			8.00
9.00	CORONARY CARE UNIT	0	0	0			9.00
10.00	BURN INTENSIVE CARE UNIT	0	0	0			10.00
11.00	SURGICAL INTENSIVE CARE UNIT	0	0	0			11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	0			13.00
14.00	Total (see instructions)	0	66	1,301	0.00	157.61	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER	0	0	0	0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY		0	0	0.00	0.00	20.00
21.00	OTHER LONG TERM CARE		0	0	0.00	0.00	21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)				0.00	0.00	23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC	0	0	0	0.00	0.00	25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	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	157.61	27.00
28.00	Observation Bed Days		0	2			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	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet S-3
Part I
Date/Time Prepared:
5/23/2018 6:13 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
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	0	17	316	1.00
2.00 HMO and other (see instructions)				0	0		2.00
3.00 HMO IPF Subprovider					0		3.00
4.00 HMO IRF Subprovider					0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0	0	0	17	316	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF	0.00	0	0	0	0	0	16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	0	17.00
18.00 SUBPROVIDER	0.00	0	0	0	0	0	18.00
19.00 SKILLED NURSING FACILITY	0.00						19.00
20.00 NURSING FACILITY	0.00						20.00
21.00 OTHER LONG TERM CARE	0.00					0	21.00
22.00 HOME HEALTH AGENCY	0.00						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)	0.00						23.00
24.00 HOSPICE	0.00						24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC	0.00						25.00
25.10 CMHC - CORF	0.00						25.10
26.00 RURAL HEALTH CLINIC	0.00						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00						26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days				0			33.00
33.01 LTCH site neutral days and discharges				0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 26-3304	Period: From 01/01/2017 To 12/31/2017	Worksheet S-10 Date/Time Prepared: 5/23/2018 6:13 pm
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.472863	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		472,842	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		981,547	6.00	
7.00	Medicaid cost (line 1 times line 6)		464,137	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		0	9.00	
10.00	Stand-alone CHIP charges		0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00	
			Uninsured patients	Insured patients	Total (col. 1 + col. 2)
			1.00	2.00	3.00
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	12,267,859	0	12,267,859	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	5,801,017	0	5,801,017	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	5,801,017	0	5,801,017	23.00
			1.00		
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		0	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		0	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		0	27.01	
28.00	Non-Medicare bad debt expense (see instructions)		0	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		0	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		5,801,017	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		5,801,017	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 26-3304		Period: From 01/01/2017 To 12/31/2017		Worksheet A	
Date/Time Prepared: 5/23/2018 6:13 pm								
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassified (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		2,792,196	2,792,196	-987,041	1,805,155	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	987,041	987,041	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	238,562	3,488,892	3,727,454	0	3,727,454	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,416,614	1,176,832	2,593,446	-623,591	1,969,855	5.00
7.00	00700	OPERATION OF PLANT	122,315	610,403	732,718	0	732,718	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	72,429	72,429	0	72,429	8.00
9.00	00900	HOUSEKEEPING	229,639	55,687	285,326	0	285,326	9.00
10.00	01000	DIETARY	0	567,867	567,867	0	567,867	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	484,321	8,019	492,340	0	492,340	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	99,456	36,719	136,175	0	136,175	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	148,974	13,737	162,711	0	162,711	16.00
17.00	01700	SOCIAL SERVICE	518,626	24,577	543,203	0	543,203	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,182,341	714,484	1,896,825	-3,209	1,893,616	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	04000	SUBPROVIDER - I PF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	658,493	6,772,109	7,430,602	-3,207,504	4,223,098	50.00
51.00	05100	RECOVERY ROOM	494,356	19,338	513,694	0	513,694	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	88,422	1,513,926	1,602,348	0	1,602,348	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	469,838	275,880	745,718	-50,947	694,771	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	159,484	283,092	442,576	-50,584	391,992	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	191,460	6,662	198,122	0	198,122	65.00
66.00	06600	PHYSICAL THERAPY	481,331	4,881	486,212	0	486,212	66.00
67.00	06700	OCCUPATIONAL THERAPY	305,701	10,743	316,444	0	316,444	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	355,951	355,951	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,473,722	3,473,722	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	230,648	256,808	487,456	0	487,456	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	288,641	22,942	311,583	0	311,583	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet A

Date/Time Prepared:
5/23/2018 6:13 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I & R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,809,222	18,728,223	26,537,445	-106,162	26,431,283	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	998,599	3,102,097	4,100,696	0	4,100,696	191.00
191.01	19101	RESEARCH	0	0	0	0	0	191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,780	0	2,780	0	2,780	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ORTHOTICS & PROSTHETICS	0	156,094	156,094	0	156,094	194.00
194.01	07951	PATIENT & FAMILY SUPPORT	0	0	0	106,162	106,162	194.01
194.02	07952	DONOR DEVELOPMENT	447,280	210,599	657,879	0	657,879	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	9,257,881	22,197,013	31,454,894	0	31,454,894	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet A
Date/Time Prepared:
5/23/2018 6:13 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	1,805,155	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	987,041	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,727,454	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,424,496	5,394,351	5.00
7.00	00700	OPERATION OF PLANT	0	732,718	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	72,429	8.00
9.00	00900	HOUSEKEEPING	0	285,326	9.00
10.00	01000	DIETARY	-164,924	402,943	10.00
11.00	01100	CAFETERIA	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	492,340	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	136,175	14.00
15.00	01500	PHARMACY	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,902	156,809	16.00
17.00	01700	SOCIAL SERVICE	0	543,203	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-983,154	910,462	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	34.00
40.00	04000	SUBPROVIDER - I PF	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-3,068,694	1,154,404	50.00
51.00	05100	RECOVERY ROOM	0	513,694	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-1,410,417	191,931	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-344,916	349,855	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-333,290	58,702	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	-571	197,551	65.00
66.00	06600	PHYSICAL THERAPY	-7,919	478,293	66.00
67.00	06700	OCCUPATIONAL THERAPY	-15,020	301,424	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	355,951	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,473,722	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-4,594	482,862	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	-669	310,914	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
99.00	09900	CMHC	0	0	99.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet A
Date/Time Prepared:
5/23/2018 6:13 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
99.10	09910	CORF	6.00	7.00	
100.00	10000	I & R SERVICES-NOT APPRVD PRGM	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	100.00
SPECIAL PURPOSE COST CENTERS					
105.00	10500	KIDNEY ACQUISITION	0	0	101.00
106.00	10600	HEART ACQUISITION	0	0	105.00
107.00	10700	LIVER ACQUISITION	0	0	106.00
108.00	10800	LUNG ACQUISITION	0	0	107.00
109.00	10900	PANCREAS ACQUISITION	0	0	108.00
110.00	11000	INTESTINAL ACQUISITION	0	0	109.00
111.00	11100	ISLET ACQUISITION	0	0	110.00
113.00	11300	INTEREST EXPENSE	0	0	111.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	114.00
116.00	11600	HOSPICE	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,915,574	23,515,709	116.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	118.00
191.00	19100	RESEARCH	0	4,100,696	190.00
191.01	19101	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,780	191.01
193.00	19300	NONPAID WORKERS	0	0	192.00
194.00	07950	ORTHOTICS & PROSTHETICS	0	156,094	193.00
194.01	07951	PATIENT & FAMILY SUPPORT	0	106,162	194.00
194.02	07952	DONOR DEVELOPMENT	0	657,879	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,915,574	28,539,320	194.02

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
A - DEPRECIATION						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	912,414	1.00	
	TOTALS		0	912,414		
B - INSURANCE						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	74,627	1.00	
	TOTALS		0	74,627		
C - MEDICAL SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	355,951	1.00	
	TOTALS		0	355,951		
D - IMPLANTS & DEVICES						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	3,473,722	1.00	
	TOTALS		0	3,473,722		
E - CHIEF OF STAFF						
1.00	OPERATING ROOM	50.00	0	623,591	1.00	
	TOTALS		0	623,591		
F - PURCHASED MEDICAL SERVICES						
1.00	PATIENT & FAMILY SUPPORT	194.01	0	106,162	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
	TOTALS		0	106,162		
500.00	Grand Total: Increases		0	5,546,467	500.00	

RECLASSIFICATIONS

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet A-6

Date/Time Prepared:
5/23/2018 6:13 pm

		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
A - DEPRECIATION								
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	912,414	9		1.00	
	TOTALS		0	912,414				
B - INSURANCE								
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	74,627	12		1.00	
	TOTALS		0	74,627				
C - MEDICAL SUPPLIES								
1.00	OPERATING ROOM	50.00	0	355,951	0		1.00	
	TOTALS		0	355,951				
D - IMPLANTS & DEVICES								
1.00	OPERATING ROOM	50.00	0	3,473,722	0		1.00	
	TOTALS		0	3,473,722				
E - CHIEF OF STAFF								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	623,591	0		1.00	
	TOTALS		0	623,591				
F - PURCHASED MEDICAL SERVICES								
1.00	ADULTS & PEDIATRICS	30.00	0	3,209	0		1.00	
2.00	OPERATING ROOM	50.00	0	1,422	0		2.00	
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	50,947	0		3.00	
4.00	LABORATORY	60.00	0	50,584	0		4.00	
	TOTALS		0	106,162				
500.00	Grand Total: Decreases		0	5,546,467			500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet A-7
Part I
Date/Time Prepared:
5/23/2018 6:13 pm

		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	4,303,290	0	0	0	0	1.00
2.00	Land Improvements	193,559	274,513	0	274,513	168,044	2.00
3.00	Buildings and Fixtures	20,311,851	47,318,622	0	47,318,622	20,311,851	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	1,906,385	151,483	0	151,483	1,906,385	5.00
6.00	Movable Equipment	8,793,349	2,462,367	0	2,462,367	3,403,009	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	35,508,434	50,206,985	0	50,206,985	25,789,289	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	35,508,434	50,206,985	0	50,206,985	25,789,289	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	4,303,290	0				1.00
2.00	Land Improvements	300,028	0				2.00
3.00	Buildings and Fixtures	47,318,622	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	151,483	0				5.00
6.00	Movable Equipment	7,852,707	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	59,926,130	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	59,926,130	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet A-7
Part II
Date/Time Prepared:
5/23/2018 6:13 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	2,655,233	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,655,233	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	2,655,233				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	2,655,233				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet A-7
Part III
Date/Time Prepared:
5/23/2018 6:13 pm

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0 1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0 2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0 3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,742,819	0 1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	912,414	0 2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,655,233	0 3.00
Cost Center Description	SUMMARY OF CAPITAL					
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	-74,627	0	0	1,668,192 1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	74,627	0	0	987,041 2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	2,655,233 3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet A-8

Date/Time Prepared:
5/23/2018 6:13 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00			3.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)	B	-1,192		ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-5,747,047				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	3,452,798				0	12.00
13.00 Laundry and linen service	B	-984		RADIOLOGY-DIAGNOSTIC	54.00	0	13.00
14.00 Cafeteria-employees and guests	B	-162,712		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	-5,902		MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines	B	-2,212		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)				UTILIZATION REVIEW-SNF	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	NONPHYSICIAN ANESTHETISTS	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)				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 ADMINISTRATION	B	-22,731		ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet A-8

Date/Time Prepared:
5/23/2018 6:13 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
33.01 LOBBYING EXPENSE	A	-4,379	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02 RESEARCH COST	A	-97,920	RADIOLOGY-DIAGNOSTIC	54.00	0	33.02
33.03 RESEARCH COST	A	-294,520	LABORATORY	60.00	0	33.03
33.04 RESEARCH COST	A	-571	RESPIRATORY THERAPY	65.00	0	33.04
33.05 RESEARCH COST	A	-7,919	PHYSICAL THERAPY	66.00	0	33.05
33.06 RESEARCH COST	A	-15,020	OCCUPATIONAL THERAPY	67.00	0	33.06
33.07 RESEARCH COST	A	-4,594	DRUGS CHARGED TO PATIENTS	73.00	0	33.07
33.08 RESEARCH COST	A	-669	CLINIC	90.00	0	33.08
33.09 OTHER ADJUSTMENTS (SPECIFY (3))		0		0.00	0	33.09
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,915,574				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: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet A-8-1

Date/Time Prepared:
5/23/2018 6:13 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	68000 INSURANCE	136,482	136,482 1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	68000 INSURANCE	74,627	74,627 2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	69000 ALLOCATED BENEFITS	2,863,737	2,863,737 3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	3,452,798	0 4.00
4.01	0.00			0	0 4.01
4.02	0.00			0	0 4.02
5.00	0		0	6,527,644	3,074,846 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	0.00	SHRI NERS	100.00	6.00
7.00		0.00		0.00	7.00
8.00		0.00		0.00	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet A-8-1

Date/Time Prepared:
5/23/2018 6:13 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	0	12	1.00
2.00	0	12	2.00
3.00	0	0	3.00
4.00	3,452,798	0	4.00
4.01	0	0	4.01
4.02	0	0	4.02
5.00	3,452,798		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	HOME OFFICE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet A-8-2

Date/Time Prepared:
5/23/2018 6:13 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	983,154	983,154	0	0	0	1.00
2.00	50.00	OPERATING ROOM	3,068,694	3,068,694	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	1,410,417	1,410,417	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	246,012	246,012	0	0	0	4.00
5.00	60.00	LABORATORY	38,770	38,770	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			5,747,047	5,747,047	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	983,154		1.00
2.00	50.00	OPERATING ROOM	0	0	0	3,068,694		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	1,410,417		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	246,012		4.00
5.00	60.00	LABORATORY	0	0	0	38,770		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	5,747,047		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet B
Part I
Date/Time Prepared:
5/23/2018 6:13 pm

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	1,805,155	1,805,155			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	987,041		987,041		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	3,727,454	6,104	3,337	3,736,895	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	5,394,351	929,069	508,006	586,934	5.00
7.00 00700	OPERATION OF PLANT	732,718	216,489	118,374	50,678	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	72,429	5,934	3,245	0	8.00
9.00 00900	HOUSEKEEPING	285,326	11,466	6,269	95,144	9.00
10.00 01000	DIETARY	402,943	9,092	4,971	0	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	492,340	2,225	1,217	200,664	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	136,175	28,484	15,575	41,207	14.00
15.00 01500	PHARMACY	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	156,809	17,230	9,421	61,723	16.00
17.00 01700	SOCIAL SERVICE	543,203	10,427	5,701	214,878	17.00
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
23.00 02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	910,462	58,493	31,984	489,869	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
32.00 03200	CORONARY CARE UNIT	0	0	0	0	32.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
40.00 04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	0	0	0	0	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00 04500	NURSING FACILITY	0	0	0	0	45.00
46.00 04600	OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	1,154,404	50,991	27,881	272,827	50.00
51.00 05100	RECOVERY ROOM	513,694	15,725	8,598	204,822	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	191,931	1,950	1,066	36,635	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	349,855	48,533	26,537	194,664	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00 05600	RADIOISOTOPE	0	0	0	0	56.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	58,702	25,856	14,138	66,078	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	197,551	4,111	2,248	79,326	65.00
66.00 06600	PHYSICAL THERAPY	478,293	27,806	15,204	199,426	66.00
67.00 06700	OCCUPATIONAL THERAPY	301,424	20,070	10,974	126,658	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	355,951	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	3,473,722	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	482,862	7,905	4,322	95,562	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	310,914	54,530	29,817	119,590	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-3304

Period:
From 01/01/2017
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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			
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00 09900 CMHC	0	0	0	0	0	99.00
99.10 09910 CORF	0	0	0	0	0	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00 10600 HEART ACQUISITION	0	0	0	0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 11600 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	23,515,709	1,552,490	848,885	3,136,685	22,524,678	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100 RESEARCH	4,100,696	180,460	98,674	413,741	4,793,571	191.00
191.01 19101 RESEARCH	0	0	0	0	0	191.01
192.00 19200 PHYSICIANS' PRIVATE OFFICES	2,780	0	0	1,152	3,932	192.00
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950 ORTHOTICS & PROSTHETICS	156,094	19,010	10,395	0	185,499	194.00
194.01 07951 PATIENT & FAMILY SUPPORT	106,162	40,373	22,076	0	168,611	194.01
194.02 07952 DONOR DEVELOPMENT	657,879	12,822	7,011	185,317	863,029	194.02
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	28,539,320	1,805,155	987,041	3,736,895	28,539,320	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
From 01/01/2017
To 12/31/2017

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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	7,418,360				5.00
7.00	00700	OPERATION OF PLANT	392,768	1,511,027			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,663	13,721	123,992		8.00
9.00	00900	HOUSEKEEPING	139,862	26,511	6,337	570,915	9.00
10.00	01000	DIETARY	146,466	21,023	2,306	8,160	594,961
11.00	01100	CAFETERIA	0	0	0	0	448,957
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	244,614	5,145	0	1,997	0
14.00	01400	CENTRAL SERVICES & SUPPLY	77,777	65,861	0	25,565	0
15.00	01500	PHARMACY	0	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	86,116	39,840	0	15,465	0
17.00	01700	SOCIAL SERVICE	271,927	24,110	0	9,359	0
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
23.00	02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	523,619	135,250	46,615	52,500	146,004
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0
40.00	04000	SUBPROVIDER - I PF	0	0	0	0	0
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
45.00	04500	NURSING FACILITY	0	0	0	0	0
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	528,992	117,903	23,551	45,766	0
51.00	05100	RECOVERY ROOM	260,909	36,361	0	14,114	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	81,339	4,508	0	1,750	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	217,619	112,218	3,373	43,560	0
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	57,874	59,784	0	23,206	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	99,482	9,507	0	3,690	0
66.00	06600	PHYSICAL THERAPY	253,143	64,293	9,772	24,956	0
67.00	06700	OCCUPATIONAL THERAPY	161,260	46,406	4,813	18,013	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	125,021	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,220,082	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	207,456	18,278	0	7,095	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	180,832	126,086	8,078	48,943	0
91.00	09100	EMERGENCY	0	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
99.00	09900	CMHC	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0

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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	
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
105.00	10500 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600 HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300 INTEREST EXPENSE						113.00
114.00	11400 UTILIZATION REVIEW-SNF						114.00
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600 HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	5,305,821	926,805	104,845	344,139	594,961	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100 RESEARCH	1,683,660	417,267	0	161,970	0	191.00
191.01	19101 RESEARCH	0	0	0	0	0	191.01
192.00	19200 PHYSICIANS' PRIVATE OFFICES	1,381	0	0	0	0	192.00
193.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950 ORTHOTICS & PROSTHETICS	65,153	43,956	0	17,062	0	194.00
194.01	07951 PATIENT & FAMILY SUPPORT	59,222	93,352	19,147	36,236	0	194.01
194.02	07952 DONOR DEVELOPMENT	303,123	29,647	0	11,508	0	194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	7,418,360	1,511,027	123,992	570,915	594,961	202.00

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Cost Center Description		CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		11.00	12.00	13.00	14.00	15.00	
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	448,957					11.00
12.00	01200		0				12.00
13.00	01300	16,265	0	964,467			13.00
14.00	01400	11,874	0	0	402,518		14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	11,918	0	0	0	0	16.00
17.00	01700	32,350	0	0	0	0	17.00
18.00	01850	0	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	61,520	0	314,766	0	0	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
34.00	03400	0	0	0	0	0	34.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	37,413	0	191,426	0	0	50.00
51.00	05100	26,839	0	137,322	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	3,629	0	18,569	0	0	53.00
54.00	05400	24,867	0	0	0	0	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	9,768	0	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	13,083	0	0	0	0	65.00
66.00	06600	26,256	0	0	0	0	66.00
67.00	06700	19,311	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	36,227	0	71.00
72.00	07200	0	0	0	366,291	0	72.00
73.00	07300	8,692	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	21,283	0	108,895	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	0	0	0	0	95.00
96.00	09600	0	0	0	0	0	96.00
97.00	09700	0	0	0	0	0	97.00
98.00	09850	0	0	0	0	0	98.00
99.00	09900	0	0	0	0	0	99.00

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Cost Center Description			CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	325,068	0	770,978	402,518		118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	37,816	0	193,489	0	0	191.00
191.01	19101	RESEARCH	0	0	0	0	0	191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ORTHOTICS & PROSTHETICS	35,218	0	0	0	0	194.00
194.01	07951	PATIENT & FAMILY SUPPORT	17,250	0	0	0	0	194.01
194.02	07952	DONOR DEVELOPMENT	33,605	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	448,957	0	964,467	402,518		202.00

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Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	NONPHYSICIAN ANESTHETISTS	PARAMED PRGM	
		16.00	17.00	18.00	19.00	23.00	
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
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
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	398,522				16.00
17.00	01700	SOCIAL SERVICE	0	1,111,955			17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0		18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
23.00	02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	27,168	1,111,955	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
40.00	04000	SUBPROVIDER - I PF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	116,932	0	0	0	50.00
51.00	05100	RECOVERY ROOM	18,843	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	39,121	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,676	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	1,411	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	8,706	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	15,953	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,306	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,726	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	82,101	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,517	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	18,062	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet B
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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	NONPHYSICIAN ANESTHETISTS	PARAMED ED PRGM		
					16.00				17.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	0	99.10
100.00	10000	I & R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS									
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE							113.00
114.00	11400	UTILIZATION REVIEW-SNF							114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	398,522	1,111,955	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS									
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	0	191.00
191.01	19101	RESEARCH	0	0	0	0	0	0	191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	0	193.00
194.00	07950	ORTHOTICS & PROSTHETICS	0	0	0	0	0	0	194.00
194.01	07951	PATIENT & FAMILY SUPPORT	0	0	0	0	0	0	194.01
194.02	07952	DONOR DEVELOPMENT	0	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments							200.00
201.00		Negative Cost Centers	0	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	398,522	1,111,955	0	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet B
Part I
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				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
12.00	01200				12.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
18.00	01850				18.00
19.00	01900				19.00
23.00	02300				23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	3,910,205	0	3,910,205	30.00
31.00	03100	0	0	0	31.00
32.00	03200	0	0	0	32.00
33.00	03300	0	0	0	33.00
34.00	03400	0	0	0	34.00
40.00	04000	0	0	0	40.00
41.00	04100	0	0	0	41.00
42.00	04200	0	0	0	42.00
43.00	04300	0	0	0	43.00
44.00	04400	0	0	0	44.00
45.00	04500	0	0	0	45.00
46.00	04600	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	2,568,086	0	2,568,086	50.00
51.00	05100	1,237,227	0	1,237,227	51.00
52.00	05200	0	0	0	52.00
53.00	05300	380,498	0	380,498	53.00
54.00	05400	1,045,902	0	1,045,902	54.00
55.00	05500	0	0	0	55.00
56.00	05600	0	0	0	56.00
57.00	05700	0	0	0	57.00
58.00	05800	0	0	0	58.00
59.00	05900	0	0	0	59.00
60.00	06000	316,817	0	316,817	60.00
60.01	06001	0	0	0	60.01
61.00	06100	0	0	0	61.00
62.00	06200	0	0	0	62.00
63.00	06300	0	0	0	63.00
64.00	06400	0	0	0	64.00
65.00	06500	417,704	0	417,704	65.00
66.00	06600	1,115,102	0	1,115,102	66.00
67.00	06700	715,235	0	715,235	67.00
68.00	06800	0	0	0	68.00
69.00	06900	0	0	0	69.00
70.00	07000	0	0	0	70.00
71.00	07100	536,925	0	536,925	71.00
72.00	07200	5,142,196	0	5,142,196	72.00
73.00	07300	851,689	0	851,689	73.00
74.00	07400	0	0	0	74.00
75.00	07500	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	0	0	0	88.00
89.00	08900	0	0	0	89.00
90.00	09000	1,027,030	0	1,027,030	90.00
91.00	09100	0	0	0	91.00
92.00	09200	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	0	0	0	94.00
95.00	09500	0	0	0	95.00
96.00	09600	0	0	0	96.00
97.00	09700	0	0	0	97.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	98.00
99.00	09900	CMHC	0	0	0	99.00
99.10	09910	CORF	0	0	0	99.10
100.00	10000	I & R SERVICES-NOT APPRVD PRGM	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00	10500	KIDNEY ACQUISITION	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,264,616	0	19,264,616	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
191.00	19100	RESEARCH	7,287,773	0	7,287,773	191.00
191.01	19101	RESEARCH	0	0	0	191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,313	0	5,313	192.00
193.00	19300	NONPAID WORKERS	0	0	0	193.00
194.00	07950	ORTHOTICS & PROSTHETICS	346,888	0	346,888	194.00
194.01	07951	PATIENT & FAMILY SUPPORT	393,818	0	393,818	194.01
194.02	07952	DONOR DEVELOPMENT	1,240,912	0	1,240,912	194.02
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	28,539,320	0	28,539,320	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet B
Part II
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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	6,104	3,337	9,441	9,441 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	929,069	508,006	1,437,075	1,482 5.00
7.00 00700	OPERATION OF PLANT	0	216,489	118,374	334,863	128 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	5,934	3,245	9,179	0 8.00
9.00 00900	HOUSEKEEPING	0	11,466	6,269	17,735	240 9.00
10.00 01000	DIETARY	0	9,092	4,971	14,063	0 10.00
11.00 01100	CAFETERIA	0	0	0	0	0 11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00 01300	NURSING ADMINISTRATION	0	2,225	1,217	3,442	507 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	28,484	15,575	44,059	104 14.00
15.00 01500	PHARMACY	0	0	0	0	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	17,230	9,421	26,651	156 16.00
17.00 01700	SOCIAL SERVICE	0	10,427	5,701	16,128	543 17.00
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0 18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
23.00 02300	PARAMEDICAL PRGM-(SPECIFY)	0	0	0	0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	58,493	31,984	90,477	1,238 30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00
32.00 03200	CORONARY CARE UNIT	0	0	0	0	0 32.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0 33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0 34.00
40.00 04000	SUBPROVIDER - I/PF	0	0	0	0	0 40.00
41.00 04100	SUBPROVIDER - I/RF	0	0	0	0	0 41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0 42.00
43.00 04300	NURSERY	0	0	0	0	0 43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
45.00 04500	NURSING FACILITY	0	0	0	0	0 45.00
46.00 04600	OTHER LONG TERM CARE	0	0	0	0	0 46.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	50,991	27,881	78,872	689 50.00
51.00 05100	RECOVERY ROOM	0	15,725	8,598	24,323	518 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00 05300	ANESTHESIOLOGY	0	1,950	1,066	3,016	93 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	48,533	26,537	75,070	492 54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0 55.00
56.00 05600	RADIOISOTOPE	0	0	0	0	0 56.00
57.00 05700	CT SCAN	0	0	0	0	0 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	0	25,856	14,138	39,994	167 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0 61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0 62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0 63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	0	4,111	2,248	6,359	200 65.00
66.00 06600	PHYSICAL THERAPY	0	27,806	15,204	43,010	504 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	20,070	10,974	31,044	320 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	7,905	4,322	12,227	241 73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	0 74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0 75.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
90.00 09000	CLINIC	0	54,530	29,817	84,347	302 90.00
91.00 09100	EMERGENCY	0	0	0	0	0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	0 94.00
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0 96.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet B
Part II
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00 09900 CMHC	0	0	0	0	0	99.00
99.10 09910 CORF	0	0	0	0	0	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00 10600 HEART ACQUISITION	0	0	0	0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 11600 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	1,552,490	848,885	2,401,375	7,924	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100 RESEARCH	0	180,460	98,674	279,134	1,046	191.00
191.01 19101 RESEARCH	0	0	0	0	0	191.01
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	3	192.00
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950 ORTHOTICS & PROSTHETICS	0	19,010	10,395	29,405	0	194.00
194.01 07951 PATIENT & FAMILY SUPPORT	0	40,373	22,076	62,449	0	194.01
194.02 07952 DONOR DEVELOPMENT	0	12,822	7,011	19,833	468	194.02
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	1,805,155	987,041	2,792,196	9,441	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 26-3304	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Prepared: 5/23/2018 6:13 pm		
Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
			5.00	7.00	8.00	9.00	10.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,438,557				5.00
7.00	00700	OPERATION OF PLANT	76,165	411,156			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,558	3,734	18,471		8.00
9.00	00900	HOUSEKEEPING	27,122	7,214	944	53,255	9.00
10.00	01000	DIETARY	28,402	5,720	344	761	49,290
11.00	01100	CAFETERIA	0	0	0	0	37,194
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	47,435	1,400	0	186	0
14.00	01400	CENTRAL SERVICES & SUPPLY	15,082	17,921	0	2,385	0
15.00	01500	PHARMACY	0	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	16,699	10,841	0	1,443	0
17.00	01700	SOCIAL SERVICE	52,731	6,560	0	873	0
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
23.00	02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	101,539	36,802	6,945	4,897	12,096
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0
40.00	04000	SUBPROVIDER - I PF	0	0	0	0	0
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
45.00	04500	NURSING FACILITY	0	0	0	0	0
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	102,581	32,082	3,508	4,269	0
51.00	05100	RECOVERY ROOM	50,595	9,894	0	1,317	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	15,773	1,227	0	163	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,200	30,535	502	4,063	0
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	11,223	16,268	0	2,165	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	19,291	2,587	0	344	0
66.00	06600	PHYSICAL THERAPY	49,089	17,494	1,456	2,328	0
67.00	06700	OCCUPATIONAL THERAPY	31,271	12,627	717	1,680	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,244	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	236,595	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	40,229	4,974	0	662	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	35,067	34,309	1,203	4,565	0
91.00	09100	EMERGENCY	0	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
99.00	09900	CMHC	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet B
Part II
Date/Time Prepared:
5/23/2018 6:13 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
100.00	10000	I & R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,028,891	252,189	15,619	32,101	49,290	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	326,499	113,538	0	15,109	0	191.00
191.01	19101	RESEARCH	0	0	0	0	0	191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	268	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ORTHOTICS & PROSTHETICS	12,634	11,961	0	1,592	0	194.00
194.01	07951	PATIENT & FAMILY SUPPORT	11,484	25,401	2,852	3,380	0	194.01
194.02	07952	DONOR DEVELOPMENT	58,781	8,067	0	1,073	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,438,557	411,156	18,471	53,255	49,290	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet B
Part II
Date/Time Prepared:
5/23/2018 6:13 pm

Cost Center Description		CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		11.00	12.00	13.00	14.00	15.00	
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	37,194					11.00
12.00	01200	0	0				12.00
13.00	01300	1,347	0	54,317			13.00
14.00	01400	984	0	0	80,535		14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	987	0	0	0	0	16.00
17.00	01700	2,680	0	0	0	0	17.00
18.00	01850	0	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	5,098	0	17,726	0	0	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
34.00	03400	0	0	0	0	0	34.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	3,099	0	10,781	0	0	50.00
51.00	05100	2,223	0	7,734	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	301	0	1,046	0	0	53.00
54.00	05400	2,060	0	0	0	0	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	809	0	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	1,084	0	0	0	0	65.00
66.00	06600	2,175	0	0	0	0	66.00
67.00	06700	1,600	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	7,248	0	71.00
72.00	07200	0	0	0	73,287	0	72.00
73.00	07300	720	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	1,763	0	6,133	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	0	0	0	0	95.00
96.00	09600	0	0	0	0	0	96.00
97.00	09700	0	0	0	0	0	97.00
98.00	09850	0	0	0	0	0	98.00
99.00	09900	0	0	0	0	0	99.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet B
Part II
Date/Time Prepared:
5/23/2018 6:13 pm

Cost Center Description			CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,930	0	43,420	80,535		118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	3,133	0	10,897	0	0	191.00
191.01	19101	RESEARCH	0	0	0	0	0	191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ORTHOTICS & PROSTHETICS	2,918	0	0	0	0	194.00
194.01	07951	PATIENT & FAMILY SUPPORT	1,429	0	0	0	0	194.01
194.02	07952	DONOR DEVELOPMENT	2,784	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	37,194	0	54,317	80,535		202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 26-3304	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Prepared: 5/23/2018 6:13 pm
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Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	NONPHYSICIAN ANESTHETISTS	PARAMED PRGM	
	16.00	17.00	18.00	19.00	23.00	
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
12.00 01200	MAINTENANCE OF PERSONNEL					12.00
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	56,777				16.00
17.00 01700	SOCIAL SERVICE	0	79,515			17.00
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0		18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
23.00 02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	3,872	79,515	0		30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0		31.00
32.00 03200	CORONARY CARE UNIT	0	0	0		32.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0		33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0		34.00
40.00 04000	SUBPROVIDER - I PF	0	0	0		40.00
41.00 04100	SUBPROVIDER - I RF	0	0	0		41.00
42.00 04200	SUBPROVIDER	0	0	0		42.00
43.00 04300	NURSERY	0	0	0		43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0		44.00
45.00 04500	NURSING FACILITY	0	0	0		45.00
46.00 04600	OTHER LONG TERM CARE	0	0	0		46.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	16,649	0	0		50.00
51.00 05100	RECOVERY ROOM	2,685	0	0		51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00 05300	ANESTHESIOLOGY	5,575	0	0		53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,516	0	0		54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
56.00 05600	RADIOISOTOPE	0	0	0		56.00
57.00 05700	CT SCAN	0	0	0		57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00 06000	LABORATORY	201	0	0		60.00
60.01 06001	BLOOD LABORATORY	0	0	0		60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0		61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00 06500	RESPIRATORY THERAPY	1,241	0	0		65.00
66.00 06600	PHYSICAL THERAPY	2,273	0	0		66.00
67.00 06700	OCCUPATIONAL THERAPY	899	0	0		67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,811	0	0		71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	11,700	0	0		72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	2,781	0	0		73.00
74.00 07400	RENAL DIALYSIS	0	0	0		74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00 09000	CLINIC	2,574	0	0		90.00
91.00 09100	EMERGENCY	0	0	0		91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0		94.00
95.00 09500	AMBULANCE SERVICES	0	0	0		95.00
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
97.00 09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0		97.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet B
Part II
Date/Time Prepared:
5/23/2018 6:13 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	NONPHYSICIAN ANESTHETISTS	PARAMED ED PRGM	
					16.00			
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0		98.00
99.00	09900	CMHC	0	0	0	0		99.00
99.10	09910	CORF	0	0	0	0		99.10
100.00	10000	I & R SERVICES-NOT APPRVD PRGM	0	0	0	0		100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0		105.00
106.00	10600	HEART ACQUISITION	0	0	0	0		106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0		107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0		108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0		111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0		113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0		114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0		115.00
116.00	11600	HOSPICE	0	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	56,777	79,515	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0	0		191.00
191.01	19101	RESEARCH	0	0	0	0		191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	ORTHOTICS & PROSTHETICS	0	0	0	0		194.00
194.01	07951	PATIENT & FAMILY SUPPORT	0	0	0	0		194.01
194.02	07952	DONOR DEVELOPMENT	0	0	0	0		194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	56,777	79,515	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 26-3304	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Prepared: 5/23/2018 6:13 pm
Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS					
1.00 00100					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
12.00 01200					12.00
13.00 01300					13.00
14.00 01400					14.00
15.00 01500					15.00
16.00 01600					16.00
17.00 01700					17.00
18.00 01850					18.00
19.00 01900					19.00
23.00 02300					23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	360,205	0	360,205		30.00
31.00 03100	0	0	0		31.00
32.00 03200	0	0	0		32.00
33.00 03300	0	0	0		33.00
34.00 03400	0	0	0		34.00
40.00 04000	0	0	0		40.00
41.00 04100	0	0	0		41.00
42.00 04200	0	0	0		42.00
43.00 04300	0	0	0		43.00
44.00 04400	0	0	0		44.00
45.00 04500	0	0	0		45.00
46.00 04600	0	0	0		46.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000	252,530	0	252,530		50.00
51.00 05100	99,289	0	99,289		51.00
52.00 05200	0	0	0		52.00
53.00 05300	27,194	0	27,194		53.00
54.00 05400	158,438	0	158,438		54.00
55.00 05500	0	0	0		55.00
56.00 05600	0	0	0		56.00
57.00 05700	0	0	0		57.00
58.00 05800	0	0	0		58.00
59.00 05900	0	0	0		59.00
60.00 06000	70,827	0	70,827		60.00
60.01 06001	0	0	0		60.01
61.00 06100	0	0	0		61.00
62.00 06200	0	0	0		62.00
63.00 06300	0	0	0		63.00
64.00 06400	0	0	0		64.00
65.00 06500	31,106	0	31,106		65.00
66.00 06600	118,329	0	118,329		66.00
67.00 06700	80,158	0	80,158		67.00
68.00 06800	0	0	0		68.00
69.00 06900	0	0	0		69.00
70.00 07000	0	0	0		70.00
71.00 07100	34,303	0	34,303		71.00
72.00 07200	321,582	0	321,582		72.00
73.00 07300	61,834	0	61,834		73.00
74.00 07400	0	0	0		74.00
75.00 07500	0	0	0		75.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800	0	0	0		88.00
89.00 08900	0	0	0		89.00
90.00 09000	170,263	0	170,263		90.00
91.00 09100	0	0	0		91.00
92.00 09200	0	0	0		92.00
OTHER REIMBURSABLE COST CENTERS					
94.00 09400	0	0	0		94.00
95.00 09500	0	0	0		95.00
96.00 09600	0	0	0		96.00
97.00 09700	0	0	0		97.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet B
Part II
Date/Time Prepared:
5/23/2018 6:13 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	98.00
99.00	09900	CMHC	0	0	0	99.00
99.10	09910	CORF	0	0	0	99.10
100.00	10000	I & R SERVICES-NOT APPRVD PRGM	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00	10500	KIDNEY ACQUISITION	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	111.00
113.00	11300	INTEREST EXPENSE				113.00
114.00	11400	UTILIZATION REVIEW-SNF				114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,786,058	0	1,786,058	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
191.00	19100	RESEARCH	749,356	0	749,356	191.00
191.01	19101	RESEARCH	0	0	0	191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	271	0	271	192.00
193.00	19300	NONPAID WORKERS	0	0	0	193.00
194.00	07950	ORTHOTICS & PROSTHETICS	58,510	0	58,510	194.00
194.01	07951	PATIENT & FAMILY SUPPORT	106,995	0	106,995	194.01
194.02	07952	DONOR DEVELOPMENT	91,006	0	91,006	194.02
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,792,196	0	2,792,196	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet B-1

Date/Time Prepared:
5/23/2018 6:13 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	85,176				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		85,176			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	288	288	9,019,319		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	43,838	43,838	1,416,614	-7,418,360	5.00
7.00 00700	OPERATION OF PLANT	10,215	10,215	122,315	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	280	280	0	0	8.00
9.00 00900	HOUSEKEEPING	541	541	229,639	0	9.00
10.00 01000	DIETARY	429	429	0	0	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	105	105	484,321	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,344	1,344	99,456	0	14.00
15.00 01500	PHARMACY	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	813	813	148,974	0	16.00
17.00 01700	SOCIAL SERVICE	492	492	518,626	0	17.00
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
23.00 02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	2,760	2,760	1,182,341	0	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
32.00 03200	CORONARY CARE UNIT	0	0	0	0	32.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
40.00 04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	0	0	0	0	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00 04500	NURSING FACILITY	0	0	0	0	45.00
46.00 04600	OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	2,406	2,406	658,493	0	50.00
51.00 05100	RECOVERY ROOM	742	742	494,356	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	92	92	88,422	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,290	2,290	469,838	0	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00 05600	RADIOISOTOPE	0	0	0	0	56.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	1,220	1,220	159,484	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	194	194	191,460	0	65.00
66.00 06600	PHYSICAL THERAPY	1,312	1,312	481,331	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	947	947	305,701	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	373	373	230,648	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	2,573	2,573	288,641	0	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet B-1

Date/Time Prepared:
5/23/2018 6:13 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	73,254	73,254	7,570,660	-7,418,360	15,106,318	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	8,515	8,515	998,599	0	4,793,571	191.00
191.01	19101	RESEARCH	0	0	0	0	0	191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	2,780	0	3,932	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ORTHOTICS & PROSTHETICS	897	897	0	0	185,499	194.00
194.01	07951	PATIENT & FAMILY SUPPORT	1,905	1,905	0	0	168,611	194.01
194.02	07952	DONOR DEVELOPMENT	605	605	447,280	0	863,029	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,805,155	987,041	3,736,895		7,418,360	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.193235	11.588253	0.414321		0.351232	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			9,441		1,438,557	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001047		0.068110	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet B-1

Date/Time Prepared:
5/23/2018 6:13 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	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	30,835				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	280	73,338			8.00	
9.00	00900	HOUSEKEEPING	541	3,748	30,014		9.00	
10.00	01000	DIETARY	429	1,364	429	19,026	10.00	
11.00	01100	CAFETERIA	0	0	0	14,357	11.00	
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00	
13.00	01300	NURSING ADMINISTRATION	105	0	105	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	1,344	0	1,344	0	14.00	
15.00	01500	PHARMACY	0	0	0	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	813	0	813	0	16.00	
17.00	01700	SOCIAL SERVICE	492	0	492	0	17.00	
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	18.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00	
23.00	02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,760	27,571	2,760	4,669	1,373	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,406	13,930	2,406	0	835	50.00
51.00	05100	RECOVERY ROOM	742	0	742	0	599	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	92	0	92	0	81	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,290	1,995	2,290	0	555	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,220	0	1,220	0	218	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	194	0	194	0	292	65.00
66.00	06600	PHYSICAL THERAPY	1,312	5,780	1,312	0	586	66.00
67.00	06700	OCCUPATIONAL THERAPY	947	2,847	947	0	431	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	373	0	373	0	194	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	2,573	4,778	2,573	0	475	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet B-1

Date/Time Prepared:
5/23/2018 6:13 pm

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,913	62,013	18,092	19,026	7,255	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	8,515	0	8,515	0	844	191.00
191.01	19101	RESEARCH	0	0	0	0	0	191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ORTHOTICS & PROSTHETICS	897	0	897	0	786	194.00
194.01	07951	PATIENT & FAMILY SUPPORT	1,905	11,325	1,905	0	385	194.01
194.02	07952	DONOR DEVELOPMENT	605	0	605	0	750	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,511,027	123,992	570,915	594,961	448,957	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	49.003632	1.690692	19.021623	31.270945	44.806088	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	411,156	18,471	53,255	49,290	37,194	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	13.334068	0.251861	1.774339	2.590665	3.711976	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet B-1

Date/Time Prepared:
5/23/2018 6:13 pm

Cost Center Description		MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (NURSING FTES)	CENTRAL SERVICES & SUPPLY (ASSIGNED TIME)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		12.00	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						11.00
12.00	01200	0					12.00
13.00	01300	0	4,207				13.00
14.00	01400	0	0	100			14.00
15.00	01500	0	0	0	100		15.00
16.00	01600	0	0	0	0	40,740,341	16.00
17.00	01700	0	0	0	0	0	17.00
18.00	01850	0	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	1,373	0	0	2,777,357	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
34.00	03400	0	0	0	0	0	34.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	835	0	0	11,953,638	50.00
51.00	05100	0	599	0	0	1,926,342	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	81	0	0	3,999,261	53.00
54.00	05400	0	0	0	0	2,522,560	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	0	144,268	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	0	0	0	890,051	65.00
66.00	06600	0	0	0	0	1,630,895	66.00
67.00	06700	0	0	0	0	644,603	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	9	0	2,016,589	71.00
72.00	07200	0	0	91	0	8,393,120	72.00
73.00	07300	0	0	0	100	1,995,230	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	475	0	0	1,846,427	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	0	0	0	0	95.00
96.00	09600	0	0	0	0	0	96.00
97.00	09700	0	0	0	0	0	97.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet B-1

Date/Time Prepared:
5/23/2018 6:13 pm

Cost Center Description			MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (NURSING FTES)	CENTRAL SERVICES & SUPPLY (ASSIGNED TIME)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			12.00	13.00	14.00	15.00	16.00	
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,363	100	100	40,740,341	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	844	0	0	0	191.00
191.01	19101	RESEARCH	0	0	0	0	0	191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ORTHOTICS & PROSTHETICS	0	0	0	0	0	194.00
194.01	07951	PATIENT & FAMILY SUPPORT	0	0	0	0	0	194.01
194.02	07952	DONOR DEVELOPMENT	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	964,467	402,518	0	398,522	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	229.252912	4,025.180000	0.000000	0.009782	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	54,317	80,535	0	56,777	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	12.911101	805.350000	0.000000	0.001394	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet B-1

Date/Time Prepared:
5/23/2018 6:13 pm

Cost Center Description	SOCIAL SERVICE (TOTAL PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (FTES)	PARAMED PRGM (ASSIGNED TIME)	
		18.00			
		17.00			
GENERAL SERVICE COST CENTERS					
1.00 00100 CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500 ADMINISTRATIVE & GENERAL					5.00
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
12.00 01200 MAINTENANCE OF PERSONNEL					12.00
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	1,301				17.00
18.00 01850 OTHER GENERAL SERVICE (SPECIFY)	0	0			18.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	8,404		19.00
23.00 02300 PARAMED PRGM-(SPECIFY)	0	0		0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS	1,301	0	1,373	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0	31.00
32.00 03200 CORONARY CARE UNIT	0	0	0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
40.00 04000 SUBPROVIDER - I/PF	0	0	0	0	40.00
41.00 04100 SUBPROVIDER - I/RF	0	0	0	0	41.00
42.00 04200 SUBPROVIDER	0	0	0	0	42.00
43.00 04300 NURSERY	0	0	0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00 04500 NURSING FACILITY	0	0	0	0	45.00
46.00 04600 OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	0	835	0	50.00
51.00 05100 RECOVERY ROOM	0	0	599	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	81	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	555	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	218	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	292	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	586	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	431	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	194	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000 CLINIC	0	0	475	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	94.00
95.00 09500 AMBULANCE SERVICES	0	0	0	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet B-1

Date/Time Prepared:
5/23/2018 6:13 pm

Cost Center Description		SOCIAL SERVICE (TOTAL PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY) (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (FTES)	PARAMED ED PRGM (ASSIGNED TIME)	
		17.00	18.00	19.00	23.00	
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
99.00	09900 CMHC	0	0	0	0	99.00
99.10	09910 CORF	0	0	0	0	99.10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	100.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00	10500 KIDNEY ACQUISITION	0	0	0	0	105.00
106.00	10600 HEART ACQUISITION	0	0	0	0	106.00
107.00	10700 LIVER ACQUISITION	0	0	0	0	107.00
108.00	10800 LUNG ACQUISITION	0	0	0	0	108.00
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	0	0	111.00
113.00	11300 INTEREST EXPENSE					113.00
114.00	11400 UTILIZATION REVIEW-SNF					114.00
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	115.00
116.00	11600 HOSPICE	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,301	0	5,639	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100 RESEARCH	0	0	844	0	191.00
191.01	19101 RESEARCH	0	0	0	0	191.01
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	19300 NONPAID WORKERS	0	0	0	0	193.00
194.00	07950 ORTHOTICS & PROSTHETICS	0	0	786	0	194.00
194.01	07951 PATIENT & FAMILY SUPPORT	0	0	385	0	194.01
194.02	07952 DONOR DEVELOPMENT	0	0	750	0	194.02
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,111,955	0	0	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	854.692544	0.000000	0.000000	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	79,515	0	0	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	61.118370	0.000000	0.000000	0.000000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)				0	206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet C
Part I
Date/Time Prepared:
5/23/2018 6:13 pm

		Title XVIII		Hospital		TEFRA	
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		3,910,205		0	0	30.00
31.00	03100 INTENSIVE CARE UNIT		0		0	0	31.00
32.00	03200 CORONARY CARE UNIT		0		0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT		0		0	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT		0		0	0	34.00
40.00	04000 SUBPROVIDER - I PF		0		0	0	40.00
41.00	04100 SUBPROVIDER - I RF		0		0	0	41.00
42.00	04200 SUBPROVIDER		0		0	0	42.00
43.00	04300 NURSERY		0		0	0	43.00
44.00	04400 SKILLED NURSING FACILITY		0		0	0	44.00
45.00	04500 NURSING FACILITY		0		0	0	45.00
46.00	04600 OTHER LONG TERM CARE		0		0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		2,568,086		0	0	50.00
51.00	05100 RECOVERY ROOM		1,237,227		0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0		0	0	52.00
53.00	05300 ANESTHESIOLOGY		380,498		0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		1,045,902		0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC		0		0	0	55.00
56.00	05600 RADIOISOTOPE		0		0	0	56.00
57.00	05700 CT SCAN		0		0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0		0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION		0		0	0	59.00
60.00	06000 LABORATORY		316,817		0	0	60.00
60.01	06001 BLOOD LABORATORY		0		0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0		0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0		0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		0		0	0	63.00
64.00	06400 INTRAVENOUS THERAPY		0		0	0	64.00
65.00	06500 RESPIRATORY THERAPY		417,704	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY		1,115,102	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY		715,235	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY		0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY		0		0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		0		0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		536,925		0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		5,142,196		0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		851,689		0	0	73.00
74.00	07400 RENAL DIALYSIS		0		0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)		0		0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC		0		0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0		0	0	89.00
90.00	09000 CLINIC		1,027,030		0	0	90.00
91.00	09100 EMERGENCY		0		0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		6,002		0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS		0		0	0	94.00
95.00	09500 AMBULANCE SERVICES		0		0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED		0		0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD		0		0	0	97.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS		0		0	0	98.00
99.00	09900 CMHC		0		0	0	99.00
99.10	09910 CORF		0		0	0	99.10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM		0		0	0	100.00
101.00	10100 HOME HEALTH AGENCY		0		0	0	101.00
SPECIAL PURPOSE COST CENTERS							
105.00	10500 KIDNEY ACQUISITION		0		0	0	105.00
106.00	10600 HEART ACQUISITION		0		0	0	106.00
107.00	10700 LIVER ACQUISITION		0		0	0	107.00
108.00	10800 LUNG ACQUISITION		0		0	0	108.00
109.00	10900 PANCREAS ACQUISITION		0		0	0	109.00
110.00	11000 INTESTINAL ACQUISITION		0		0	0	110.00
111.00	11100 ISLET ACQUISITION		0		0	0	111.00
113.00	11300 INTEREST EXPENSE						113.00
114.00	11400 UTILIZATION REVIEW-SNF						114.00
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)		0		0	0	115.00
116.00	11600 HOSPICE		0		0	0	116.00
200.00	Subtotal (see instructions)		19,270,618	0	0	0	200.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 26-3304		Period: From 01/01/2017 To 12/31/2017		Worksheet C Part I Date/Time Prepared: 5/23/2018 6:13 pm	
		Title XVIII		Hospital		TEFRA	
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	
201.00	Less Observation Beds	6,002		6,002			0 201.00
202.00	Total (see instructions)	19,264,616	0	19,264,616	0		0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 26-3304		Period: From 01/01/2017 To 12/31/2017		Worksheet C Part I Date/Time Prepared: 5/23/2018 6:13 pm		
			Title XVIII			Hospital		TEFRA	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	2,768,957		2,768,957				30.00
31.00	03100	INTENSIVE CARE UNIT	0		0				31.00
32.00	03200	CORONARY CARE UNIT	0		0				32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0				33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0				34.00
40.00	04000	SUBPROVIDER - I PF	0		0				40.00
41.00	04100	SUBPROVIDER - I RF	0		0				41.00
42.00	04200	SUBPROVIDER	0		0				42.00
43.00	04300	NURSERY	0		0				43.00
44.00	04400	SKILLED NURSING FACILITY	0		0				44.00
45.00	04500	NURSING FACILITY	0		0				45.00
46.00	04600	OTHER LONG TERM CARE	0		0				46.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	4,842,840	7,110,798	11,953,638	0.214837	0.214837		50.00
51.00	05100	RECOVERY ROOM	575,389	1,350,953	1,926,342	0.642268	0.642268		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	1,473,170	2,526,091	3,999,261	0.095142	0.095142		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	247,720	2,274,840	2,522,560	0.414619	0.414619		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000		55.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000		56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000		59.00
60.00	06000	LABORATORY	72,336	71,932	144,268	2.196031	2.196031		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000		60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	0.000000		61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	0.000000		62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	737,655	152,396	890,051	0.469303	0.469303		65.00
66.00	06600	PHYSICAL THERAPY	337,316	1,293,579	1,630,895	0.683736	0.683736		66.00
67.00	06700	OCCUPATIONAL THERAPY	51,150	593,453	644,603	1.109574	1.109574		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,810,546	206,043	2,016,589	0.266254	0.266254		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,693,381	699,739	8,393,120	0.612668	0.612668		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,230,317	764,913	1,995,230	0.426863	0.426863		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000		75.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0				88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0				89.00
90.00	09000	CLINIC	2,896	1,843,531	1,846,427	0.556226	0.556226		90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	951	7,449	8,400	0.714524	0.714524		92.00
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	0.000000		94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	0.000000		97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000		98.00
99.00	09900	CMHC	0	0	0				99.00
99.10	09910	CORF	0	0	0				99.10
100.00	10000	I & R SERVICES-NOT APPRVD PRGM	0	0	0				100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0				101.00
SPECIAL PURPOSE COST CENTERS									
105.00	10500	KIDNEY ACQUISITION	0	0	0				105.00
106.00	10600	HEART ACQUISITION	0	0	0				106.00
107.00	10700	LIVER ACQUISITION	0	0	0				107.00
108.00	10800	LUNG ACQUISITION	0	0	0				108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0				109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0				110.00
111.00	11100	ISLET ACQUISITION	0	0	0				111.00
113.00	11300	INTEREST EXPENSE	0	0	0				113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0				114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0				115.00
116.00	11600	HOSPICE	0	0	0				116.00
200.00		Subtotal (see instructions)	21,844,624	18,895,717	40,740,341				200.00
201.00		Less Observation Beds							201.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 26-3304		Period: From 01/01/2017 To 12/31/2017		Worksheet C Part I Date/Time Prepared: 5/23/2018 6:13 pm	
			Title XVIII		Hospital		TEFRA	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col . 6 + col . 7)			
6.00			7.00	8.00	9.00	10.00		
202.00	Total (see instructions)		21,844,624	18,895,717	40,740,341			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 26-3304	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/23/2018 6:13 pm
Cost Center Description			PPS Inpatient Ratio 11.00	Title XVIII	Hospital TEFRA
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
32.00	03200	CORONARY CARE UNIT			32.00
33.00	03300	BURN INTENSIVE CARE UNIT			33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT			34.00
40.00	04000	SUBPROVIDER - I PF			40.00
41.00	04100	SUBPROVIDER - I RF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
46.00	04600	OTHER LONG TERM CARE			46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000		61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
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
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		94.00
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000		97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
99.00	09900	CMHC			99.00
99.10	09910	CORF			99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM			100.00
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
105.00	10500	KIDNEY ACQUISITION			105.00
106.00	10600	HEART ACQUISITION			106.00
107.00	10700	LIVER ACQUISITION			107.00
108.00	10800	LUNG ACQUISITION			108.00
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)			115.00
116.00	11600	HOSPICE			116.00
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: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet C
Part I
Date/Time Prepared:
5/23/2018 6:13 pm

		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	3,910,205		3,910,205	0	3,910,205	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0		0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00
40.00	04000	SUBPROVIDER - I PF	0		0	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	0		0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,568,086		2,568,086	0	2,568,086	50.00
51.00	05100	RECOVERY ROOM	1,237,227		1,237,227	0	1,237,227	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	380,498		380,498	0	380,498	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,045,902		1,045,902	0	1,045,902	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	316,817		316,817	0	316,817	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	417,704	0	417,704	0	417,704	65.00
66.00	06600	PHYSICAL THERAPY	1,115,102	0	1,115,102	0	1,115,102	66.00
67.00	06700	OCCUPATIONAL THERAPY	715,235	0	715,235	0	715,235	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	536,925		536,925	0	536,925	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,142,196		5,142,196	0	5,142,196	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	851,689		851,689	0	851,689	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	1,027,030		1,027,030	0	1,027,030	90.00
91.00	09100	EMERGENCY	0		0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	6,002		6,002	0	6,002	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0		0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
99.00	09900	CMHC	0		0	0	0	99.00
99.10	09910	CORF	0		0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0		0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0		0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	0		0	0	0	105.00
106.00	10600	HEART ACQUISITION	0		0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0		0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0		0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0		0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0		0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0		0	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0		0	0	0	114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		0	0	0	115.00
116.00	11600	HOSPICE	0		0	0	0	116.00
200.00		Subtotal (see instructions)	19,270,618	0	19,270,618	0	19,270,618	200.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 26-3304		Period: From 01/01/2017 To 12/31/2017		Worksheet C Part I Date/Time Prepared: 5/23/2018 6:13 pm	
		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	
201.00	Less Observation Beds	6,002		6,002		6,002	201.00
202.00	Total (see instructions)	19,264,616	0	19,264,616	0	19,264,616	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 26-3304		Period: From 01/01/2017 To 12/31/2017		Worksheet C Part I Date/Time Prepared: 5/23/2018 6:13 pm		
			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	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	2,768,957		2,768,957				30.00
31.00	03100	INTENSIVE CARE UNIT	0		0				31.00
32.00	03200	CORONARY CARE UNIT	0		0				32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0				33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0				34.00
40.00	04000	SUBPROVIDER - I PF	0		0				40.00
41.00	04100	SUBPROVIDER - I RF	0		0				41.00
42.00	04200	SUBPROVIDER	0		0				42.00
43.00	04300	NURSERY	0		0				43.00
44.00	04400	SKILLED NURSING FACILITY	0		0				44.00
45.00	04500	NURSING FACILITY	0		0				45.00
46.00	04600	OTHER LONG TERM CARE	0		0				46.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	4,842,840	7,110,798	11,953,638	0.214837	0.000000		50.00
51.00	05100	RECOVERY ROOM	575,389	1,350,953	1,926,342	0.642268	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	1,473,170	2,526,091	3,999,261	0.095142	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	247,720	2,274,840	2,522,560	0.414619	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000		55.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000		56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000		59.00
60.00	06000	LABORATORY	72,336	71,932	144,268	2.196031	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000		60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	0.000000		61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	0.000000		62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	737,655	152,396	890,051	0.469303	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	337,316	1,293,579	1,630,895	0.683736	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	51,150	593,453	644,603	1.109574	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,810,546	206,043	2,016,589	0.266254	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,693,381	699,739	8,393,120	0.612668	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,230,317	764,913	1,995,230	0.426863	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000		75.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000		89.00
90.00	09000	CLINIC	2,896	1,843,531	1,846,427	0.556226	0.000000		90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	951	7,449	8,400	0.714524	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	0.000000		94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	0.000000		97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000		98.00
99.00	09900	CMHC	0	0	0	0.000000	0.000000		99.00
99.10	09910	CORF	0	0	0	0.000000	0.000000		99.10
100.00	10000	I & R SERVICES-NOT APPRVD PRGM	0	0	0	0.000000	0.000000		100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0.000000	0.000000		101.00
SPECIAL PURPOSE COST CENTERS									
105.00	10500	KIDNEY ACQUISITION	0	0	0				105.00
106.00	10600	HEART ACQUISITION	0	0	0				106.00
107.00	10700	LIVER ACQUISITION	0	0	0				107.00
108.00	10800	LUNG ACQUISITION	0	0	0				108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0				109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0				110.00
111.00	11100	ISLET ACQUISITION	0	0	0				111.00
113.00	11300	INTEREST EXPENSE	0	0	0				113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0				114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0				115.00
116.00	11600	HOSPICE	0	0	0				116.00
200.00		Subtotal (see instructions)	21,844,624	18,895,717	40,740,341				200.00
201.00		Less Observation Beds							201.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 26-3304		Period: From 01/01/2017 To 12/31/2017		Worksheet C Part I Date/Time Prepared: 5/23/2018 6:13 pm	
			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	10.00		
202.00	Total (see instructions)		21,844,624	18,895,717	40,740,341			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 26-3304	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/23/2018 6:13 pm	
Cost Center Description			PPS Inpatient Ratio 11.00	Title XIX	Hospital	Cost
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
32.00	03200	CORONARY CARE UNIT				32.00
33.00	03300	BURN INTENSIVE CARE UNIT				33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT				34.00
40.00	04000	SUBPROVIDER - I PF				40.00
41.00	04100	SUBPROVIDER - I RF				41.00
42.00	04200	SUBPROVIDER				42.00
43.00	04300	NURSERY				43.00
44.00	04400	SKILLED NURSING FACILITY				44.00
45.00	04500	NURSING FACILITY				45.00
46.00	04600	OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
60.01	06001	BLOOD LABORATORY	0.000000			60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000			61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
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
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000			75.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0.000000			94.00
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000			96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000			97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000			98.00
99.00	09900	CMHC				99.00
99.10	09910	CORF				99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM				100.00
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
105.00	10500	KIDNEY ACQUISITION				105.00
106.00	10600	HEART ACQUISITION				106.00
107.00	10700	LIVER ACQUISITION				107.00
108.00	10800	LUNG ACQUISITION				108.00
109.00	10900	PANCREAS ACQUISITION				109.00
110.00	11000	INTESTINAL ACQUISITION				110.00
111.00	11100	ISLET ACQUISITION				111.00
113.00	11300	INTEREST EXPENSE				113.00
114.00	11400	UTILIZATION REVIEW-SNF				114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)				115.00
116.00	11600	HOSPICE				116.00
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: 26-3304	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part I Date/Time Prepared: 5/23/2018 6:13 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	360,205	0	360,205	1,303	276.44	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
32.00	CORONARY CARE UNIT	0		0	0	0.00	32.00
33.00	BURN INTENSIVE CARE UNIT	0		0	0	0.00	33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0		0	0	0.00	34.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	0		0	0	0.00	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (lines 30 through 199)	360,205		360,205	1,303		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	0	0				
31.00	INTENSIVE CARE UNIT	0	0				
32.00	CORONARY CARE UNIT	0	0				
33.00	BURN INTENSIVE CARE UNIT	0	0				
34.00	SURGICAL INTENSIVE CARE UNIT	0	0				
40.00	SUBPROVIDER - IPF	0	0				
41.00	SUBPROVIDER - IRF	0	0				
42.00	SUBPROVIDER	0	0				
43.00	NURSERY	0	0				
44.00	SKILLED NURSING FACILITY	0	0				
45.00	NURSING FACILITY	0	0				
200.00	Total (lines 30 through 199)	0	0				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 26-3304	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part II Date/Time Prepared: 5/23/2018 6:13 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	252,530	11,953,638	0.021126	0	0	50.00
51.00	05100 RECOVERY ROOM	99,289	1,926,342	0.051543	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	27,194	3,999,261	0.006800	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	158,438	2,522,560	0.062808	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	70,827	144,268	0.490940	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	31,106	890,051	0.034949	0	0	65.00
66.00	06600 PHYSICAL THERAPY	118,329	1,630,895	0.072555	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	80,158	644,603	0.124353	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	34,303	2,016,589	0.017010	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	321,582	8,393,120	0.038315	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	61,834	1,995,230	0.030991	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000 CLINIC	170,263	1,846,427	0.092212	0	0	90.00
91.00	09100 EMERGENCY	0	0	0.000000	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	553	8,400	0.065833	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00	Total (lines 50 through 199)	1,426,406	37,971,384		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 26-3304	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part III Date/Time Prepared: 5/23/2018 6:13 pm
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Cost Center Description		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
		1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
200.00		Total (lines 30 through 199)	0	0	0	0	200.00
Cost Center Description		Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
		4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	1,303	0.00	0 30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0.00	0 31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0.00	0 32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0.00	0 33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0.00	0 34.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0 40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0 41.00
42.00	04200	SUBPROVIDER	0	0	0	0.00	0 42.00
43.00	04300	NURSERY	0	0	0	0.00	0 43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0.00	0 44.00
45.00	04500	NURSING FACILITY	0	0	0	0.00	0 45.00
200.00		Total (lines 30 through 199)	0	0	1,303	0	0 200.00
Cost Center Description		Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
		9.00					
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0				30.00
31.00	03100	INTENSIVE CARE UNIT	0				31.00
32.00	03200	CORONARY CARE UNIT	0				32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0				33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0				34.00
40.00	04000	SUBPROVIDER - IPF	0				40.00
41.00	04100	SUBPROVIDER - IRF	0				41.00
42.00	04200	SUBPROVIDER	0				42.00
43.00	04300	NURSERY	0				43.00
44.00	04400	SKILLED NURSING FACILITY	0				44.00
45.00	04500	NURSING FACILITY	0				45.00
200.00		Total (lines 30 through 199)	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 26-3304	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/23/2018 6:13 pm
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Cost Center Description	Title XVIII				Hospital		Allied Health
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	TEFRA	
	1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
90.00 09000 CLINIC	0	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	0	94.00
95.00 09500 AMBULANCE SERVICES	0	0	0	0	0	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	0	98.00
200.00 Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 26-3304	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/23/2018 6:13 pm
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Cost Center Description	Title XVIII			Hospital	TEFRA			
	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)			
	4.00	5.00	6.00	7.00	8.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	11,953,638	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,926,342	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,999,261	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,522,560	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	144,268	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0.000000	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0.000000	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	890,051	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,630,895	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	644,603	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,016,589	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8,393,120	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,995,230	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	1,846,427	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	8,400	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0.000000	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0.000000	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0.000000	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0.000000	98.00
200.00		Total (lines 50 through 199)	0	0	0	37,971,384		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 26-3304	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/23/2018 6:13 pm
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Cost Center Description		Title XVIII				Hospital	
		Outpatient Ratio of Cost to Charges (col. 6 + col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	TEFRA
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00
95.00	09500 AMBULANCE SERVICES	0.000000	0	0	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00	Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 26-3304	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/23/2018 6:13 pm
		Title XVIII	Hospital	TEFRA

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.214837	0	0	0	0 50.00
51.00 05100 RECOVERY ROOM	0.642268	0	0	0	0 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0 52.00
53.00 05300 ANESTHESIOLOGY	0.095142	0	0	0	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.414619	0	0	0	0 54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0 55.00
56.00 05600 RADIOISOTOPE	0.000000	0	0	0	0 56.00
57.00 05700 CT SCAN	0.000000	0	0	0	0 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0 58.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0 59.00
60.00 06000 LABORATORY	2.196031	0	0	0	0 60.00
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0 60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	0 61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0 62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0 63.00
64.00 06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0 64.00
65.00 06500 RESPIRATORY THERAPY	0.469303	0	0	0	0 65.00
66.00 06600 PHYSICAL THERAPY	0.683736	0	0	0	0 66.00
67.00 06700 OCCUPATIONAL THERAPY	1.109574	0	0	0	0 67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	0	0	0	0 68.00
69.00 06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0 69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.266254	0	0	0	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.612668	0	0	0	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.426863	0	0	0	0 73.00
74.00 07400 RENAL DIALYSIS	0.000000	0	0	0	0 74.00
75.00 07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0 75.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0.000000				0 88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0 89.00
90.00 09000 CLINIC	0.556226	0	0	0	0 90.00
91.00 09100 EMERGENCY	0.000000	0	0	0	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.714524	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS					
94.00 09400 HOME PROGRAM DIALYSIS	0.000000		0		0 94.00
95.00 09500 AMBULANCE SERVICES	0.000000		0		0 95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0 96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0 97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0 98.00
200.00 Subtotal (see instructions)		0	0	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	0	0	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 26-3304	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/23/2018 6:13 pm
	Title XVIII	Hospital	TEFRA

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
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00 05600 RADIOISOTOPE	0	0		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		75.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
OTHER REIMBURSABLE COST CENTERS				
94.00 09400 HOME PROGRAM DIALYSIS	0	0		94.00
95.00 09500 AMBULANCE SERVICES	0	0		95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00 Subtotal (see instructions)	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0	0		201.00
202.00 Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 26-3304	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part III Date/Time Prepared: 5/23/2018 6:13 pm
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Cost Center Description		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	Cost
		1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
40.00	04000	SUBPROVIDER - I PF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
200.00		Total (lines 30 through 199)	0	0	0	0	200.00
Cost Center Description		Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
		4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	1,303	0.00	66 30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0.00	0 31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0.00	0 32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0.00	0 33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0.00	0 34.00
40.00	04000	SUBPROVIDER - I PF	0	0	0	0.00	0 40.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0.00	0 41.00
42.00	04200	SUBPROVIDER	0	0	0	0.00	0 42.00
43.00	04300	NURSERY	0	0	0	0.00	0 43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0.00	0 44.00
45.00	04500	NURSING FACILITY	0	0	0	0.00	0 45.00
200.00		Total (lines 30 through 199)	0	0	1,303	0.00	66 200.00
Cost Center Description		Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
		9.00					
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0				30.00
31.00	03100	INTENSIVE CARE UNIT	0				31.00
32.00	03200	CORONARY CARE UNIT	0				32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0				33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0				34.00
40.00	04000	SUBPROVIDER - I PF	0				40.00
41.00	04100	SUBPROVIDER - I RF	0				41.00
42.00	04200	SUBPROVIDER	0				42.00
43.00	04300	NURSERY	0				43.00
44.00	04400	SKILLED NURSING FACILITY	0				44.00
45.00	04500	NURSING FACILITY	0				45.00
200.00		Total (lines 30 through 199)	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 26-3304	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/23/2018 6:13 pm
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Cost Center Description	Title XIX				Hospital		Allied Health Cost
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
	1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 26-3304	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/23/2018 6:13 pm
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Cost Center Description	Title XIX			Hospital	Cost			
	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)			
	4.00	5.00	6.00	7.00	8.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	11,953,638	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,926,342	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,999,261	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,522,560	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	144,268	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0.000000	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0.000000	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	890,051	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,630,895	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	644,603	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,016,589	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8,393,120	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,995,230	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	1,846,427	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	8,400	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0.000000	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0.000000	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0.000000	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0.000000	98.00
200.00		Total (lines 50 through 199)	0	0	0	37,971,384		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 26-3304	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/23/2018 6:13 pm
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Cost Center Description		Title XIX			Hospital		Cost
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	190,683	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	25,785	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	61,227	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	10,454	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	3,366	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	38,185	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	17,890	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	4,522	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	137,519	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	268,141	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	48,591	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000 CLINIC	0.000000	497	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00
95.00	09500 AMBULANCE SERVICES	0.000000	0	0	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00	Total (lines 50 through 199)		806,860	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 26-3304	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/23/2018 6:13 pm
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Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
		1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.214837	0	0	375,562	0
51.00	05100 RECOVERY ROOM	0.642268	0	0	70,268	0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0
53.00	05300 ANESTHESIOLOGY	0.095142	0	0	130,599	0
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.414619	0	0	14,104	0
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0
57.00	05700 CT SCAN	0.000000	0	0	0	0
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00	06000 LABORATORY	2.196031	0	0	0	0
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	0
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0
65.00	06500 RESPIRATORY THERAPY	0.469303	0	0	5,510	0
66.00	06600 PHYSICAL THERAPY	0.683736	0	0	3,625	0
67.00	06700 OCCUPATIONAL THERAPY	1.109574	0	0	213	0
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.266254	0	0	12,086	0
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.612668	0	0	21,813	0
73.00	07300 DRUGS CHARGED TO PATIENTS	0.426863	0	0	42,612	0
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0.000000				0
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0
90.00	09000 CLINIC	0.556226	0	0	3,316	0
91.00	09100 EMERGENCY	0.000000	0	0	0	0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.714524	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0.000000		0		94.00
95.00	09500 AMBULANCE SERVICES	0.000000	0	0		95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0
200.00	Subtotal (see instructions)		0	0	679,708	0
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 - line 201)		0	0	679,708	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 26-3304	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/23/2018 6:13 pm
	Title XIX	Hospital	Cost

Cost Center Description	Costs		Hospital	Cost
	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	80,685		50.00
51.00 05100 RECOVERY ROOM	0	45,131		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	12,425		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	5,848		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00 05600 RADIOISOTOPE	0	0		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	2,586		65.00
66.00 06600 PHYSICAL THERAPY	0	2,479		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	236		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,218		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	13,364		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	18,189		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		75.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00 09000 CLINIC	0	1,844		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
OTHER REIMBURSABLE COST CENTERS				
94.00 09400 HOME PROGRAM DIALYSIS	0	0		94.00
95.00 09500 AMBULANCE SERVICES	0	0		95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00 Subtotal (see instructions)	0	186,005		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	0	186,005		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-3304	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/23/2018 6:13 pm
Cost Center Description				TEFRA
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,303	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,303	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)		1,301	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,910,205	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,910,205	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,910,205	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)		3,000.92	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		0	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		0	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 26-3304		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1	
Title XVIII			Hospital		TEFRA			
Cost Center Description			Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
			1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)		0	0	0.00	0	0 42.00	
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT		0	0	0.00	0	0 43.00	
44.00	CORONARY CARE UNIT		0	0	0.00	0	0 44.00	
45.00	BURN INTENSIVE CARE UNIT		0	0	0.00	0	0 45.00	
46.00	SURGICAL INTENSIVE CARE UNIT		0	0	0.00	0	0 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)							
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)							
PASS THROUGH COST ADJUSTMENTS								
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)							
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)							
52.00	Total Program excludable cost (sum of lines 50 and 51)							
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)							
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges							
55.00	Target amount per discharge		0.00 54.00					
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)							
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)							
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)							
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)							
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)							
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)							
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							
72.00	Program routine service cost (line 9 x line 71)							
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							
76.00	Per diem capital-related costs (line 75 ÷ line 2)							
77.00	Program capital-related costs (line 9 x line 76)							
78.00	Inpatient routine service cost (line 74 minus line 77)							
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							
81.00	Inpatient routine service cost per diem limitation							
82.00	Inpatient routine service cost limitation (line 9 x line 81)							
83.00	Reasonable inpatient routine service costs (see instructions)							
84.00	Program inpatient ancillary services (see instructions)							
85.00	Utilization review - physician compensation (see instructions)							
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)		2 87.00					
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		3,000.92 88.00					
89.00	Observation bed cost (line 87 x line 88) (see instructions)		6,002 89.00					

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-3304		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 5/23/2018 6:13 pm	
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	360,205	3,910,205	0.092119	6,002	553	90.00
91.00	Nursing School cost	0	3,910,205	0.000000	6,002	0	91.00
92.00	Allied health cost	0	3,910,205	0.000000	6,002	0	92.00
93.00	All other Medical Education	0	3,910,205	0.000000	6,002	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-3304	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1
				Date/Time Prepared: 5/23/2018 6:13 pm
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)			1,303 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,303 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)			1,301 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)			66 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			3,910,205 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			3,910,205 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			3,910,205 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)			3,000.92 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			198,061 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)			198,061 41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 26-3304	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/23/2018 6:13 pm
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)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0
44.00 CORONARY CARE UNIT	0	0	0.00	0	0
45.00 BURN INTENSIVE CARE UNIT	0	0	0.00	0	0
46.00 SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0
47.00 OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					332,161
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					530,222
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
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00 Total Program excludable cost (sum of lines 50 and 51)					0
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					2
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					3,000.92
89.00 Observation bed cost (line 87 x line 88) (see instructions)					6,002

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-3304		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 5/23/2018 6:13 pm	
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	360,205	3,910,205	0.092119	6,002	553	90.00
91.00	Nursing School cost	0	3,910,205	0.000000	6,002	0	91.00
92.00	Allied health cost	0	3,910,205	0.000000	6,002	0	92.00
93.00	All other Medical Education	0	3,910,205	0.000000	6,002	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 26-3304	Period: From 01/01/2017 To 12/31/2017	Worksheet D-3 Date/Time Prepared: 5/23/2018 6:13 pm	
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		140,470	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
32.00	03200	CORONARY CARE UNIT		0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	34.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.214837	190,683	40,966 50.00
51.00	05100	RECOVERY ROOM	0.642268	25,785	16,561 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0.095142	61,227	5,825 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.414619	10,454	4,334 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0 55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0 56.00
57.00	05700	CT SCAN	0.000000	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	06000	LABORATORY	2.196031	3,366	7,392 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0 61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0 62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0 63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0.469303	38,185	17,920 65.00
66.00	06600	PHYSICAL THERAPY	0.683736	17,890	12,232 66.00
67.00	06700	OCCUPATIONAL THERAPY	1.109574	4,522	5,017 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.266254	137,519	36,615 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.612668	268,141	164,281 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.426863	48,591	20,742 73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0 74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0 75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0 89.00
90.00	09000	CLINIC	0.556226	497	276 90.00
91.00	09100	EMERGENCY	0.000000	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.714524	0	0 92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0 94.00
95.00	09500	AMBULANCE SERVICES			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0 96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0 97.00
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)		806,860	332,161 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net charges (line 200 minus line 201)		806,860	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-3304	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/23/2018 6:13 pm
		Title XVIII	Hospital	TEFRA
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	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)		0	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)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		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)		0	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)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	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)		0	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		0	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		0	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		0	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: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet E-1
Part I
Date/Time Prepared:
5/23/2018 6:13 pm

		Title XVIII		Hospital	TEFRA	
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		0		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 26-3304	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/23/2018 6:13 pm
		Title XVIII	Hospital	TEFRA
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-3304	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part I Date/Time Prepared: 5/23/2018 6:13 pm
		Title XVIII	Hospital	TEFRA
				1.00
PART I - MEDICARE PART A SERVICES - TEFRA				
1.00	Inpatient hospital services (see instructions)			0 1.00
1.01	Nursing and allied health managed care payment (see instructions)			0 1.01
2.00	Organ acquisition			0 2.00
3.00	Cost of physicians' services in a teaching hospital (see instructions)			0 3.00
4.00	Subtotal (sum of lines 1 through 3)			0 4.00
5.00	Primary payer payments			0 5.00
6.00	Subtotal (line 4 less line 5)			0 6.00
7.00	Deductibles			0 7.00
8.00	Subtotal (line 6 minus line 7)			0 8.00
9.00	Coinsurance			0 9.00
10.00	Subtotal (line 8 minus line 9)			0 10.00
11.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 11.00
12.00	Adjusted reimbursable bad debts (see instructions)			0 12.00
13.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 13.00
14.00	Subtotal (sum of lines 10 and 12)			0 14.00
15.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 15.00
16.00	DO NOT USE THIS LINE			0 16.00
17.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 17.00
17.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 17.50
17.99	Demonstration payment adjustment amount before sequestration			0 17.99
18.00	Total amount payable to the provider (see instructions)			0 18.00
18.01	Sequestration adjustment (see instructions)			0 18.01
18.02	Demonstration payment adjustment amount after sequestration			0 18.02
19.00	Interim payments			0 19.00
20.00	Tentative settlement (for contractor use only)			0 20.00
21.00	Balance due provider/program (line 18 minus lines 18.01, 18.02, 19, and 20)			0 21.00
22.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 22.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-3304	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part VII Date/Time Prepared: 5/23/2018 6:13 pm	
		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		530,222		1.00
2.00	Medical and other services			186,005	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		530,222	186,005	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)		530,222	186,005	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		140,470		8.00
9.00	Ancillary service charges		806,860	679,708	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)		947,330	679,708	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)		947,330	679,708	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		417,108	493,703	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	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)		530,222	186,005	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)		530,222	186,005	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		530,222	186,005	31.00
32.00	Deductibles		0	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)		530,222	186,005	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		530,222	186,005	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)		530,222	186,005	40.00
41.00	Interim payments		146,318	61,671	41.00
42.00	Balance due provider/program (line 40 minus line 41)		383,904	124,334	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: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet G

Date/Time Prepared:
5/23/2018 6:13 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	71,618	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	9,863,056	0	0	0	4.00
5.00	Other receivable	1,317	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-7,973,868	0	0	0	6.00
7.00	Inventory	988,517	0	0	0	7.00
8.00	Prepaid expenses	270,995	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)	3,221,635	0	0	0	11.00
FIXED ASSETS						
12.00	Land	4,154,898	0	0	0	12.00
13.00	Land improvements	300,027	0	0	0	13.00
14.00	Accumulated depreciation	-259,349	0	0	0	14.00
15.00	Buildings	40,275,038	0	0	0	15.00
16.00	Accumulated depreciation	-4,010,272	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	577,019	0	0	0	19.00
20.00	Accumulated depreciation	-93,570	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	10,754,174	0	0	0	23.00
24.00	Accumulated depreciation	-6,238,943	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)	45,459,022	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	3,532,802	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,532,802	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	52,213,459	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,520,265	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,146,030	0	0	0	38.00
39.00	Payroll taxes payable	27,172	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	2,932,915	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	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,626,382	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	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	5,626,382	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	46,587,076				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	46,587,076	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	52,213,458	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet G-1

Date/Time Prepared:
5/23/2018 6:13 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		9,157,929		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-12,414,254				2.00
3.00	Total (sum of line 1 and line 2)		-3,256,325		0		3.00
4.00	Additions (credit adjustments) (specify)	49,843,401		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		49,843,401		0		10.00
11.00	Subtotal (line 3 plus line 10)		46,587,076		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		46,587,076		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/23/2018 6:13 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,768,957		2,768,957	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	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	0		0	8.00
9.00	OTHER LONG TERM CARE	0		0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,768,957		2,768,957	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT	0		0	12.00
13.00	BURN INTENSIVE CARE UNIT	0		0	13.00
14.00	SURGICAL INTENSIVE CARE UNIT	0		0	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)	2,768,957		2,768,957	17.00
18.00	Ancillary services	21,777,721	22,979,452	44,757,173	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	0	0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC	0	0	0	24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	25.00
26.00	HOSPICE	0	0	0	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)	24,546,678	22,979,452	47,526,130	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		31,454,894		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)		31,454,894		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 26-3304

Period:
From 01/01/2017
To 12/31/2017

Worksheet G-3

Date/Time Prepared:
5/23/2018 6:13 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	47,526,130	1.00
2.00	Less contractual allowances and discounts on patients' accounts	38,648,241	2.00
3.00	Net patient revenues (line 1 minus line 2)	8,877,889	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	31,454,894	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-22,577,005	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	5,127,230	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	0	10.00
11.00	Rebates and refunds of expenses	1,192	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	164,925	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	5,902	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	3,988,393	23.00
24.00	OTHER INCOME	157,641	24.00
24.01	GRANT INCOME	645,393	24.01
24.02	MEANINGFUL USE	72,075	24.02
25.00	Total other income (sum of lines 6-24)	10,162,751	25.00
26.00	Total (line 5 plus line 25)	-12,414,254	26.00
27.00	OTHER EXPENSES (SPECIFY)	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)	-12,414,254	29.00