

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 26-2010		Period: From 09/01/2017 To 08/31/2018		Worksheet S-2 Part I Date/Time Prepared: 12/13/2018 9:20 am			
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00 Street: 4930 Lindell Boulevard		PO Box:						1.00			
2.00 City: St. Louis		State: MO		Zip Code: 63108		County: St. Louis City		2.00			
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
1.00		2.00		3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:											
3.00 Hospital		Kindred Hospital St. Louis		262010	41180	2	08/30/1991	N	P	O	3.00
4.00 Subprovider - IPF											4.00
5.00 Subprovider - IRF											5.00
6.00 Subprovider - (Other)											6.00
7.00 Swing Beds - SNF											7.00
8.00 Swing Beds - NF											8.00
9.00 Hospital-Based SNF											9.00
10.00 Hospital-Based NF											10.00
11.00 Hospital-Based OLTC											11.00
12.00 Hospital-Based HHA											12.00
13.00 Separately Certified ASC											13.00
14.00 Hospital-Based Hospice											14.00
15.00 Hospital-Based Health Clinic - RHC											15.00
16.00 Hospital-Based Health Clinic - FQHC											16.00
17.00 Hospital-Based (CMHC) I											17.00
18.00 Renal Dialysis											18.00
19.00 Other											19.00
							From:	To:			
							1.00	2.00			
20.00 Cost Reporting Period (mm/dd/yyyy)							09/01/2017	08/31/2018		20.00	
21.00 Type of Control (see instructions)							4			21.00	
							1.00	2.00	3.00		
Inpatient PPS Information											
22.00 Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N	N			22.00	
22.01 Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						N	N			22.01	
22.02 Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N			22.02	
22.03 Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N	N		22.03	
23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.							2	N		23.00	
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid 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	0	24.00

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		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0	25.00	
		Urban/Rural		S		Date of Geogr			
		1.00		2.00					
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00	
		Beginning:		Ending:					
		1.00		2.00					
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPSS final rule? Enter "Y" for yes or "N" for no. (see instructions)					N		37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
		Y/N		Y/N					
		1.00		2.00					
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00	
		V		XVII		XIX			
		1.00		2.00		3.00			
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	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

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	Y/N	IME	Direct GME	IME	Direct GME		
	1.00	2.00	3.00	4.00	5.00		
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
						1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00			
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		66.00
	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.					Y	80.00		
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.					Y	81.00		
TEFRA Providers									
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N	85.00		
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00		
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.					N	87.00		
						V	XIX		
						1.00	2.00		
Title V and XIX Services									
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N		Y	90.00		
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N		N	91.00		
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N	92.00		
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N		N	93.00		
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N		N	94.00		
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00				0.00	95.00		
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N		N	96.00		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00				0.00	97.00		
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y		Y	98.00		
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 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)						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.			N		N		N	109.00
						1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.					N			110.00

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		1.00	2.00			
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	22,301	0	99,974		
		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.	N				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.	Y		5.00		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		189003		140.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 26-2010		Period: From 09/01/2017 To 08/31/2018		Worksheet S-2 Part II Date/Time Prepared: 12/13/2018 9:20 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		03/31/2019		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
				Y/N			
				1.00			1.00
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				N		14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				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)	Y	11/30/2018	Y	11/30/2018		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 26-2010	Period: From 09/01/2017 To 08/31/2018	Worksheet S-2 Part II Date/Time Prepared: 12/13/2018 9:20 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N	N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		Y	12/31/2018	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00		2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAVID		SIMPSON	41.00
42.00	Enter the employer/company name of the cost report preparer.	KINDRED HEALTHCARE OPERATING LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5025967945		KindredReimbursement@kindred.com	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 26-2010	Period: From 09/01/2017 To 08/31/2018	Worksheet S-2 Part II Date/Time Prepared: 12/13/2018 9:20 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA		Provider CCN: 26-2010		Period: From 09/01/2017 To 08/31/2018		Worksheet S-3 Part I Date/Time Prepared: 12/13/2018 9:20 am	
Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P		
	Line Number				Visits / Trips	Title V	
	1.00	2.00	3.00	4.00	5.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	92	33,580	0.00	0	1.00	
2.00 HMO and other (see instructions)						2.00	
3.00 HMO IPF Subprovider						3.00	
4.00 HMO IRF Subprovider						4.00	
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00	
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00	
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		92	33,580	0.00	0	7.00	
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00	
9.00 CORONARY CARE UNIT						9.00	
10.00 BURN INTENSIVE CARE UNIT						10.00	
11.00 SURGICAL INTENSIVE CARE UNIT						11.00	
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00	
13.00 NURSERY						13.00	
14.00 Total (see instructions)		92	33,580	0.00	0	14.00	
15.00 CAH visits					0	15.00	
16.00 SUBPROVIDER - IPF						16.00	
17.00 SUBPROVIDER - IRF						17.00	
18.00 SUBPROVIDER						18.00	
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	19.00	
20.00 NURSING FACILITY						20.00	
21.00 OTHER LONG TERM CARE						21.00	
22.00 HOME HEALTH AGENCY						22.00	
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00	
24.00 HOSPICE						24.00	
24.10 HOSPICE (non-distinct part)	30.00					24.10	
25.00 CMHC - CMHC						25.00	
26.00 RURAL HEALTH CLINIC						26.00	
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25	
27.00 Total (sum of lines 14-26)		92			0	27.00	
28.00 Observation Bed Days					0	28.00	
29.00 Ambulance Trips						29.00	
30.00 Employee discount days (see instruction)						30.00	
31.00 Employee discount days - IRF						31.00	
32.00 Labor & delivery days (see instructions)		0	0			32.00	
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01	
33.00 LTCH non-covered days						33.00	
33.01 LTCH site neutral days and discharges						33.01	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 26-2010

Period:
From 09/01/2017
To 08/31/2018

Worksheet S-3
Part I
Date/Time Prepared:
12/13/2018 9:20 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	8,732	1,726	19,478			1.00
2.00 HMO and other (see instructions)	3,132	157				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)	8,732	1,726	19,478			7.00
8.00 INTENSIVE CARE UNIT	0	0	0			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	8,732	1,726	19,478	0.00	182.00	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	182.00	27.00
28.00 Observation Bed Days		0	0			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	162					33.00
33.01 LTCH site neutral days and discharges	1,516					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 26-2010

Period:
From 09/01/2017
To 08/31/2018

Worksheet S-3
Part I
Date/Time Prepared:
12/13/2018 9:20 am

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	339	54	686	1.00
2.00 HMO and other (see instructions)			110	4		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	339	54	686	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			61			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 26-2010

Period:
From 09/01/2017
To 08/31/2018

Worksheet S-3
Part II
Date/Time Prepared:
12/13/2018 9:20 am

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	12,310,564	0	12,310,564	378,876.39	32.49
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		0	50,544	50,544	1,176.00	42.98
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		3,310,295	0	3,310,295	58,431.00	56.65
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		200,173	0	200,173	1,678.00	119.29
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		1,611,478	0	1,611,478	34,279.47	47.01
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		1,802,211	0	1,802,211		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		7,184	0	7,184		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	115,749	0	115,749	1,829.38	63.27
27.00	Administrative & General	5.00	1,751,907	0	1,751,907	38,203.40	45.86

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 26-2010

Period:
From 09/01/2017
To 08/31/2018

Worksheet S-3
Part II
Date/Time Prepared:
12/13/2018 9:20 am

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)	11,507	0	11,507	296.56	38.80	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	229,364	0	229,364	15,107.00	15.18	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	133,311	0	133,311	4,581.00	29.10	34.00
35.00	Dietary under contract (see instructions)	0	0	0	0.00	0.00	35.00
36.00	Cafeteria	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	1,519,849	0	1,519,849	34,327.00	44.28	38.00
39.00	Central Services and Supply	103,376	0	103,376	6,254.00	16.53	39.00
40.00	Pharmacy	616,809	0	616,809	14,100.00	43.75	40.00
41.00	Medical Records & Medical Records Library	453,738	0	453,738	14,737.00	30.79	41.00
42.00	Social Service	869,484	-50,544	818,940	18,920.00	43.28	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 26-2010

Period:
From 09/01/2017
To 08/31/2018

Worksheet S-3
Part III
Date/Time Prepared:
12/13/2018 9:20 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	12,322,071	0	12,322,071	379,172.95	32.50	1.00
2.00	Excluded area salaries (see instructions)	0	50,544	50,544	1,176.00	42.98	2.00
3.00	Subtotal salaries (line 1 minus line 2)	12,322,071	-50,544	12,271,527	377,996.95	32.46	3.00
4.00	Subtotal other wages & related costs (see inst.)	5,121,946	0	5,121,946	94,388.47	54.26	4.00
5.00	Subtotal wage-related costs (see inst.)	1,802,211	0	1,802,211	0.00	14.69	5.00
6.00	Total (sum of lines 3 thru 5)	19,246,228	-50,544	19,195,684	472,385.42	40.64	6.00
7.00	Total overhead cost (see instructions)	5,805,094	-50,544	5,754,550	148,355.34	38.79	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 26-2010	Period: From 09/01/2017 To 08/31/2018	Worksheet S-3 Part IV Date/Time Prepared: 12/13/2018 9:20 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			12,386 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0 4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			0 8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)			0 8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		742,242	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		8,801	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		6,899	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		44,650	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		-504	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		863,675	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		0	19.00
20.00	State or Federal Unemployment Taxes		64,005	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		60,057	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		1,802,211	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 26-2010	Period: From 09/01/2017 To 08/31/2018	Worksheet S-3 Part V Date/Time Prepared: 12/13/2018 9:20 am
Cost Center Description			Contract Labor	Benefit Cost
			1.00	2.00
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		3,310,295	1,802,211
2.00	Hospital		3,310,295	1,802,211
3.00	Subprovider - IPF			
4.00	Subprovider - IRF			
5.00	Subprovider - (Other)		0	0
6.00	Swing Beds - SNF		0	0
7.00	Swing Beds - NF		0	0
8.00	Hospital-Based SNF		0	0
9.00	Hospital-Based NF			
10.00	Hospital-Based OLTC			
11.00	Hospital-Based HHA			
12.00	Separately Certified ASC			
13.00	Hospital-Based Hospice			
14.00	Hospital-Based Health Clinic RHC			
15.00	Hospital-Based Health Clinic FQHC			
16.00	Hospital-Based-CMHC			
17.00	Renal Dialysis		0	0
18.00	Other		0	0

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 26-2010	Period: From 09/01/2017 To 08/31/2018	Worksheet A Date/Time Prepared: 12/13/2018 9:20 am		
Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)		
	1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT		2,188,139	2,188,139	87,346	2,275,485	1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		851,670	851,670	142,423	994,093	2.00
3.00 00300	OTHER CAP REL COSTS		237,795	237,795	-237,795	0	3.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	115,749	1,913,747	2,029,496	0	2,029,496	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	1,751,907	5,745,451	7,497,358	-8,495	7,488,863	5.00
7.00 00700	OPERATION OF PLANT	0	851,113	851,113	-61,869	789,244	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	117,342	117,342	0	117,342	8.00
9.00 00900	HOUSEKEEPING	229,364	104,200	333,564	54	333,618	9.00
10.00 01000	DIETARY	133,311	659,265	792,576	500	793,076	10.00
11.00 01100	CAFETERIA	0	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	1,519,849	14,801	1,534,650	28	1,534,678	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	103,376	11,614	114,990	116,636	231,626	14.00
15.00 01500	PHARMACY	616,809	440,288	1,057,097	4,817	1,061,914	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	453,738	90,285	544,023	0	544,023	16.00
17.00 01700	SOCIAL SERVICE	869,484	53,121	922,605	-53,741	868,864	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	4,784,357	2,469,239	7,253,596	615,877	7,869,473	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	221,972	136,610	358,582	0	358,582	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	74,247	296,373	370,620	8,855	379,475	54.00
60.00 06000	LABORATORY	80,586	376,502	457,088	13,280	470,368	60.00
65.00 06500	RESPIRATORY THERAPY	1,355,815	84,500	1,440,315	292,084	1,732,399	65.00
66.00 06600	PHYSICAL THERAPY	0	1,229,723	1,229,723	25,712	1,255,435	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,275,439	1,275,439	-999,453	275,986	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	1,362,290	1,362,290	0	1,362,290	73.00
74.00 07400	RENAL DIALYSIS	0	550,807	550,807	0	550,807	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	0	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00 09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	12,310,564	21,060,314	33,370,878	-53,741	33,317,137	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00 07950	NONALLOWABLE CLINICAL LIAISON	0	0	0	53,741	53,741	194.00
194.01 07951	IDLE SPACE	0	0	0	0	0	194.01
194.02 07952	REGIONAL OFFICE	0	0	0	0	0	194.02
194.03 07953	DISTRICT OFFICE	0	0	0	0	0	194.03
194.04 07954	NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
194.05 07955	REG NURSG OFFICE	0	0	0	0	0	194.05
194.06 07956	CONTACT CENTER	0	0	0	0	0	194.06
194.07 07957	CENTRALIZED ADMINISTRATIONS DEPT	0	0	0	0	0	194.07
194.08 07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.08
194.09 07958	VISITOR MEALS	0	0	0	0	0	194.09
194.10 07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11 07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
200.00	TOTAL (SUM OF LINES 118 through 199)	12,310,564	21,060,314	33,370,878	0	33,370,878	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 26-2010

Period:
From 09/01/2017
To 08/31/2018

Worksheet A
Date/Time Prepared:
12/13/2018 9:20 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	27,536	2,303,021	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-97,019	897,074	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	28,543	2,058,039	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-512,405	6,976,458	5.00
7.00	00700	OPERATION OF PLANT	-1,491	787,753	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	117,342	8.00
9.00	00900	HOUSEKEEPING	0	333,618	9.00
10.00	01000	DIETARY	-2,154	790,922	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,534,678	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	231,626	14.00
15.00	01500	PHARMACY	0	1,061,914	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	832	544,855	16.00
17.00	01700	SOCIAL SERVICE	0	868,864	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-499,161	7,370,312	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	358,582	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-95,106	284,369	54.00
60.00	06000	LABORATORY	0	470,368	60.00
65.00	06500	RESPIRATORY THERAPY	1,525	1,733,924	65.00
66.00	06600	PHYSICAL THERAPY	-77,185	1,178,250	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	275,986	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,362,290	73.00
74.00	07400	RENAL DIALYSIS	-2,474	548,333	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,228,559	32,088,578	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	53,741	194.00
194.01	07951	IDLE SPACE	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	194.05
194.06	07956	CONTACT CENTER	0	0	194.06
194.07	07957	CENTRALIZED ADMINISTRATIONS DEPT	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	194.11
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,228,559	32,142,319	200.00

RECLASSIFICATIONS

Provider CCN: 26-2010

Period:
From 09/01/2017
To 08/31/2018

Worksheet A-6

Date/Time Prepared:
12/13/2018 9:20 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - RECLASS NON ALLOWABLE CASE MANAGER					
1.00	NONALLOWABLE CLINICAL	194.00	50,544	3,197	1.00
	LIASON				
	TOTALS		50,544	3,197	
B - RCL OXYGEN					
1.00	RESPIRATORY THERAPY	65.00	0	44,362	1.00
	TOTALS		0	44,362	
C - RCL NON-CHARGEABLE MED SUPPLIES					
1.00		0.00	0	0	1.00
2.00	OPERATION OF PLANT	7.00	0	1,819	2.00
4.00	HOUSEKEEPING	9.00	0	54	4.00
5.00	DIETARY	10.00	0	500	5.00
6.00	NURSING ADMINISTRATION	13.00	0	28	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	116,636	7.00
8.00	PHARMACY	15.00	0	4,817	8.00
11.00	ADULTS & PEDIATRICS	30.00	0	615,877	11.00
16.00	LABORATORY	60.00	0	10,640	16.00
17.00	RESPIRATORY THERAPY	65.00	0	187,503	17.00
18.00	PHYSICAL THERAPY	66.00	0	25,712	18.00
	TOTALS		0	963,586	
D - RCL JLL EQUIPMENT SVC CONTRACTS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00		8,855	1.00
2.00	LABORATORY	60.00		2,640	2.00
3.00	RESPIRATORY THERAPY	65.00		52,193	3.00
	TOTALS		0	63,688	
E - RCL OXYGEN IN ACCT 74010					
1.00	RESPIRATORY THERAPY	65.00	0	8,026	1.00
	TOTALS		0	8,026	
500.00	Grand Total: Increases		50,544	1,082,859	500.00

RECLASSIFICATIONS

Provider CCN: 26-2010

Period:
From 09/01/2017
To 08/31/2018

Worksheet A-6

Date/Time Prepared:
12/13/2018 9:20 am

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - RECLASS NON ALLOWABLE CASE MANAGER						
1.00	SOCIAL SERVICE	17.00	50,544	3,197	0	1.00
	TOTALS		50,544	3,197		
B - RCL OXYGEN						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	44,362	0	1.00
	TOTALS		0	44,362		
C - RCL NON-CHARGEABLE MED SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	955,091	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	8,495	0	2.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
11.00		0.00	0	0	0	11.00
16.00		0.00	0	0	0	16.00
17.00		0.00	0	0	0	17.00
18.00		0.00	0	0	0	18.00
	TOTALS		0	963,586		
D - RCL JLL EQUIPMENT SVC CONTRACTS						
1.00	OPERATION OF PLANT	7.00	0	63,688	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		0	63,688		
E - RCL OXYGEN IN ACCT 74010						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	8,026	10	1.00
	TOTALS		0	8,026		
500.00	Grand Total: Decreases		50,544	1,082,859		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-2010

Period:
From 09/01/2017
To 08/31/2018

Worksheet A-7
Part I
Date/Time Prepared:
12/13/2018 9:20 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	3.00
4.00	Building Improvements	3,453,780	55,511	0	55,511	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	5,852,801	211,602	0	211,602	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	9,306,581	267,113	0	267,113	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	9,306,581	267,113	0	267,113	10.00
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	0	0			3.00
4.00	Building Improvements	3,509,291	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	6,044,561	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	9,553,852	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	9,553,852	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-2010

Period:
From 09/01/2017
To 08/31/2018

Worksheet A-7
Part II
Date/Time Prepared:
12/13/2018 9:20 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	262,228	1,925,911	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	406,896	444,774	0	0	0	2.00
3.00	Total (sum of lines 1-2)	669,124	2,370,685	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	2,188,139				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	851,670				2.00
3.00	Total (sum of lines 1-2)	0	3,039,809				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-2010

Period:
From 09/01/2017
To 08/31/2018

Worksheet A-7
Part III
Date/Time Prepared:
12/13/2018 9:20 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	3,509,291	0	3,509,291	0.367317	9,811	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,044,562	0	6,044,562	0.632683	16,898	2.00
3.00	Total (sum of lines 1-2)	9,553,853	0	9,553,853	1.000000	26,709	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	77,535	0	87,346	299,913	1,925,911	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	133,551	0	150,449	309,877	436,748	2.00
3.00	Total (sum of lines 1-2)	211,086	0	237,795	609,790	2,362,659	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	-338	77,535	0	2,303,021	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	16,898	133,551	0	897,074	2.00
3.00	Total (sum of lines 1-2)	0	16,560	211,086	0	3,200,095	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 26-2010

Period:
From 09/01/2017
To 08/31/2018

Worksheet A-8

Date/Time Prepared:
12/13/2018 9:20 am

Line #	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 #			
				3.00	4.00			
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)			0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-8,244		ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-1,567		CAP REL COSTS-BLDG & FIXT	1.00	9	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-43,160		ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-1,491		OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)			0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-624,506				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	574,189				0	12.00
13.00	Laundry and linen service			0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-526		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	-1,202		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	-1,628		DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant			0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 26-2010

Period:
From 09/01/2017
To 08/31/2018

Worksheet A-8

Date/Time Prepared:
12/13/2018 9:20 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		3.00
33.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.00
33.01 MISCELLANEOUS INCOME	B	-91,353	ADMINISTRATIVE & GENERAL		5.00	0 33.01
33.02 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.02
33.03 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.03
33.04 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.04
33.05 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.05
33.06 PATIENT PERSONAL SERVICES EXPENSE	A	-1,841	ADMINISTRATIVE & GENERAL		5.00	0 33.06
33.07 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.07
33.08 MEDICARE BAD DEBT - PART A	A	-570,483	ADMINISTRATIVE & GENERAL		5.00	0 33.08
33.09 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.09
33.10 OTHER MEDICARE NON ALLOWABLE	A	-62,751	ADMINISTRATIVE & GENERAL		5.00	0 33.10
33.11 OTHER OPERATING - PATIENT RELATIONS	A	-566	ADMINISTRATIVE & GENERAL		5.00	0 33.11
33.12 OTHER OPERATING - PUBLIC RELATIONS	A	-972	ADMINISTRATIVE & GENERAL		5.00	0 33.12
33.13 OTHER OPERATING - MARKETING	A	-132,115	ADMINISTRATIVE & GENERAL		5.00	0 33.13
33.14 OTHER OPERATING - INTEREST	A	-174	ADMINISTRATIVE & GENERAL		5.00	0 33.14
33.15 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.15
33.16 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.16
33.17 OTHER OPER - LITIGATION SETTLEMENT	A	-20,000	ADMINISTRATIVE & GENERAL		5.00	0 33.17
33.18 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.18
33.19 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.19
33.20 OTHER OPERATING - TRADE SHOW BOOTH	A	-459	ADMINISTRATIVE & GENERAL		5.00	0 33.20
33.21 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.21
33.22 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.22
33.23 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.23
33.24 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.24
33.25 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.25
33.26 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.26
33.27 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.27
33.28 AGGREGATE CAPITAL EROSION	A	-27,387	ADMINISTRATIVE & GENERAL		5.00	0 33.28
33.29 CABLE TV AND SATELLITE	A	-8,220	ADMINISTRATIVE & GENERAL		5.00	0 33.29
33.30 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.30
33.31 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.31
33.32 RENT - OTHER	A	-53,222	ADMINISTRATIVE & GENERAL		5.00	0 33.32
33.33 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.33
33.34 MALPRACTICE TAIL LIABILITY	A	-26,935	ADMINISTRATIVE & GENERAL		5.00	0 33.34
33.35 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.35
33.36 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.36
33.37 PHYSICIAN BILLING COLLECTION FEES	A	23	ADMINISTRATIVE & GENERAL		5.00	0 33.37
33.38 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.38
33.39 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.39

ADJUSTMENTS TO EXPENSES

Provider CCN: 26-2010

Period:
From 09/01/2017
To 08/31/2018

Worksheet A-8

Date/Time Prepared:
12/13/2018 9:20 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		3.00
33.40 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.40
33.41 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.41
33.42 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.42
33.43 DISTRICT OFFICE SALES AND MARKETING	A	-37,932	ADMINISTRATIVE & GENERAL		5.00	0 33.43
33.44 DISTRICT OFC SALES AND MKT BENEFITS	A	-2,533	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.44
33.45 BUSINESS INTERRUPTIONS INS PREMIUM	A	-10,149	CAP REL COSTS-BLDG & FIXT		1.00	12 33.45
34.00 MEDICARE VS BOOK BLDG	A	28,826	CAP REL COSTS-BLDG & FIXT		1.00	9 34.00
34.01 MEDICARE VS BOOK MOV EQUIP	A	-131,543	CAP REL COSTS-MVBLE EQUIP		2.00	9 34.01
34.02 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.02
34.03 ASSET ADD-ON BLDG	A	10,426	CAP REL COSTS-BLDG & FIXT		1.00	9 34.03
34.04 ASSET ADD-ON MOV EQUIP	A	39,528	CAP REL COSTS-MVBLE EQUIP		2.00	9 34.04
34.05 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.05
34.06 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.06
34.07 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.07
34.08 NON ALLOWABLE LOBBYING FEES	A	-10,307	ADMINISTRATIVE & GENERAL		5.00	0 34.08
34.09 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.09
34.10 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.10
34.11 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.11
34.12 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.12
34.13 PATIENT PHONE - DEPRECEQUIP	A	-3,489	CAP REL COSTS-MVBLE EQUIP		2.00	9 34.13
34.14 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.14
34.15 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.15
34.16 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.16
34.17 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.17
34.18 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.18
34.19 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.19
34.20 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.20
34.21 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.21
34.22 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.22
34.23 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.23
34.24 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.24
34.25 FRA Tax - Adjust to Actual	A	-5,282	ADMINISTRATIVE & GENERAL		5.00	0 34.25
34.26 Asset Transfer Allocation	A	-1,515	CAP REL COSTS-MVBLE EQUIP		2.00	9 34.26
34.27 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.27
34.28 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.28
35.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.00
35.01 PHYSICIAN FEE ADJUSTMENT	A	-31,323	ADMINISTRATIVE & GENERAL		5.00	0 35.01
35.02 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.02
35.03 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.03
35.04 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.04

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00		3.00	4.00
35.05 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	35.05
35.06 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	35.06
35.07 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	35.07
35.08 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	35.08
35.09 PHYSICIAN FEE ADJUSTMENT	A	3,849	MEDICAL RECORDS & LIBRARY		16.00	0	35.09
35.10 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	35.10
35.11 PHYSICIAN FEE ADJUSTMENT	A	23,166	ADULTS & PEDIATRICS		30.00	0	35.11
35.12 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	35.12
35.13 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	35.13
35.14 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	35.14
35.15 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	35.15
35.16 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	35.16
35.17 PHYSICIAN FEE ADJUSTMENT	A	6,159	RESPIRATORY THERAPY		65.00	0	35.17
35.18 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	35.18
35.19 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	35.19
35.20 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	35.20
35.21 PHYSICIAN FEE ADJUSTMENT	A	-1,850	RENAL DIALYSIS		74.00	0	35.21
35.22 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	35.22
35.23 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	35.23
35.24 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	35.24
35.25 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	35.25
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,228,559					50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS
 Provider CCN: 26-2010
 Period: From 09/01/2017 To 08/31/2018
 Worksheet A-8-1
 Date/Time Prepared: 12/13/2018 9:20 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	Home Office Costs	2,497,746	1,761,334
2.00	0.00			0	0
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	Workers Comp Premium	0	-31,076
4.00	5.00	ADMINISTRATIVE & GENERAL	Liability Insurance	0	116,114
4.01	66.00	PHYSICAL THERAPY	Therapy Services	1,145,177	1,222,362
5.00	0			3,642,923	3,068,734

* 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	KHOLLC	100.00	Admin & Gen	100.00	6.00
7.00	B	KHOLLC	100.00	Cornerstone	100.00	7.00
8.00	B	KHOLLC	100.00	Cornerstone	100.00	8.00
9.00	B	KHOLLC	100.00	RehabCare	100.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 26-2010	Period: From 09/01/2017 To 08/31/2018	Worksheet A-8-1 Date/Time Prepared: 12/13/2018 9:20 am
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	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	736,412	0		1.00
2.00	0	0		2.00
3.00	31,076	0		3.00
4.00	-116,114	0		4.00
4.01	-77,185	0		4.01
5.00	574,189			5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

Related Organization(s) and/or Home Office	Type of Business	
		6.00
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	HomeOffice Cost		6.00
7.00	Worker Comp Ins		7.00
8.00	Liability Insur		8.00
9.00	Therapy Svcs		9.00
10.00			10.00
100.00			100.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 26-2010

Period:
From 09/01/2017
To 08/31/2018

Worksheet A-8-2

Date/Time Prepared:
12/13/2018 9:20 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	0.00		0	0	0	0	0	1.00
2.00	54.00	DR. B	94,380	94,380	0	271,900	0	2.00
3.00	30.00	DR. C	1,808	0	1,808	211,500	9	3.00
4.00	65.00	DR. D	2,434	0	2,434	211,500	15	4.00
5.00	65.00	DR. E	3,725	3,725	0	211,500	0	5.00
6.00	30.00	DR. F	392,615	392,615	0	211,500	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	30.00	DR. H	16,350	0	16,350	211,500	55	8.00
9.00	74.00	DR. I	360	0	360	211,500	2	9.00
10.00	0.00		0	0	0	0	0	10.00
14.00	30.00	DR. N	146,300	0	146,300	211,500	1,463	14.00
15.00	16.00	DR. O	1,999	0	1,999	211,500	10	15.00
16.00	74.00	DR. P	975	0	975	211,500	5	16.00
17.00	16.00	DR. Q	740	0	740	211,500	4	17.00
18.00	30.00	DR. R	2,498	0	2,498	211,500	14	18.00
19.00	30.00	DR. S	1,356	0	1,356	211,500	9	19.00
20.00	54.00	DR. T	1,380	0	1,380	271,900	5	20.00
21.00	30.00	DR. U	115,413	115,413	0	211,500	0	21.00
22.00	30.00	DR. V	2,150	0	2,150	211,500	10	22.00
23.00	16.00	DR. W	1,110	0	1,110	211,500	6	23.00
200.00			785,593	606,133	179,460		1,607	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	0.00		0	0	0	0	0	1.00
2.00	54.00	DR. B	0	0	0	0	0	2.00
3.00	30.00	DR. C	915	46	0	0	0	3.00
4.00	65.00	DR. D	1,525	76	0	0	0	4.00
5.00	65.00	DR. E	0	0	0	0	0	5.00
6.00	30.00	DR. F	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	30.00	DR. H	5,592	280	0	0	0	8.00
9.00	74.00	DR. I	203	10	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
14.00	30.00	DR. N	148,762	7,438	0	0	0	14.00
15.00	16.00	DR. O	1,017	51	0	0	0	15.00
16.00	74.00	DR. P	508	25	0	0	0	16.00
17.00	16.00	DR. Q	407	20	0	0	0	17.00
18.00	30.00	DR. R	1,424	71	0	0	0	18.00
19.00	30.00	DR. S	915	46	0	0	0	19.00
20.00	54.00	DR. T	654	33	0	0	0	20.00
21.00	30.00	DR. U	0	0	0	0	0	21.00
22.00	30.00	DR. V	1,017	51	0	0	0	22.00
23.00	16.00	DR. W	610	31	0	0	0	23.00
200.00			163,549	8,178	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	0.00		0	0	0	0		1.00
2.00	54.00	DR. B	0	0	0	94,380		2.00
3.00	30.00	DR. C	0	915	893	893		3.00
4.00	65.00	DR. D	0	1,525	909	909		4.00
5.00	65.00	DR. E	0	0	0	3,725		5.00
6.00	30.00	DR. F	0	0	0	392,615		6.00
7.00	0.00		0	0	0	0		7.00
8.00	30.00	DR. H	0	5,592	10,758	10,758		8.00
9.00	74.00	DR. I	0	203	157	157		9.00
10.00	0.00		0	0	0	0		10.00
14.00	30.00	DR. N	0	148,762	0	0		14.00
15.00	16.00	DR. O	0	1,017	982	982		15.00
16.00	74.00	DR. P	0	508	467	467		16.00
17.00	16.00	DR. Q	0	407	333	333		17.00
18.00	30.00	DR. R	0	1,424	1,074	1,074		18.00
19.00	30.00	DR. S	0	915	441	441		19.00
20.00	54.00	DR. T	0	654	726	726		20.00
21.00	30.00	DR. U	0	0	0	115,413		21.00
22.00	30.00	DR. V	0	1,017	1,133	1,133		22.00
23.00	16.00	DR. W	0	610	500	500		23.00
200.00			0	163,549	18,373	624,506		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-2010

Period:
From 09/01/2017
To 08/31/2018

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Part I
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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	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,303,021	2,303,021			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	897,074		897,074		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,058,039	6,548	2,551	2,067,138	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	6,976,458	382,738	149,084	296,966	5.00
7.00 00700	OPERATION OF PLANT	787,753	120,136	46,795	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	117,342	49,742	19,375	0	8.00
9.00 00900	HOUSEKEEPING	333,618	34,882	13,587	38,879	9.00
10.00 01000	DIETARY	790,922	78,286	30,494	22,598	10.00
11.00 01100	CAFETERIA	0	29,551	11,511	0	11.00
13.00 01300	NURSING ADMINISTRATION	1,534,678	74,550	29,039	257,630	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	231,626	139,613	54,382	17,523	14.00
15.00 01500	PHARMACY	1,061,914	140,536	54,742	104,555	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	544,855	52,344	20,389	76,913	16.00
17.00 01700	SOCIAL SERVICE	868,864	33,119	12,901	138,819	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	7,370,312	951,222	370,520	810,991	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	358,582	7,975	3,107	37,626	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	284,369	34,127	13,293	12,586	54.00
60.00 06000	LABORATORY	470,368	41,724	16,252	13,660	60.00
65.00 06500	RESPIRATORY THERAPY	1,733,924	53,729	20,929	229,824	65.00
66.00 06600	PHYSICAL THERAPY	1,178,250	39,877	15,533	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	275,986	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,362,290	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	548,333	32,322	12,590	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00 09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	32,088,578	2,303,021	897,074	2,058,570	32,080,010
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	NONALLOWABLE CLINICAL LIAISON	53,741	0	0	8,568	194.00
194.01 07951	IDLE SPACE	0	0	0	0	194.01
194.02 07952	REGIONAL OFFICE	0	0	0	0	194.02
194.03 07953	DISTRICT OFFICE	0	0	0	0	194.03
194.04 07954	NON MCR CERTIFIED UNIT	0	0	0	0	194.04
194.05 07955	REG NURSG OFFICE	0	0	0	0	194.05
194.06 07956	CONTACT CENTER	0	0	0	0	194.06
194.07 07957	CENTRALIZED ADMINISTRATIONS DEPT	0	0	0	0	194.07
194.08 07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.08
194.09 07958	VISITOR MEALS	0	0	0	0	194.09
194.10 07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.10
194.11 07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	32,142,319	2,303,021	897,074	2,067,138	32,142,319

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-2010

Period:
From 09/01/2017
To 08/31/2018

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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	7,805,246				5.00
7.00	00700	OPERATION OF PLANT	306,181	1,260,865			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	59,800	34,967	281,226		8.00
9.00	00900	HOUSEKEEPING	135,010	24,521	0	580,497	9.00
10.00	01000	DIETARY	295,795	55,033	0	26,592	1,299,720
11.00	01100	CAFETERIA	13,169	20,774	0	10,038	601,512
13.00	01300	NURSING ADMINISTRATION	608,041	52,407	0	25,323	0
14.00	01400	CENTRAL SERVICES & SUPPLY	142,122	98,145	0	47,423	0
15.00	01500	PHARMACY	436,731	98,794	0	47,737	0
16.00	01600	MEDICAL RECORDS & LIBRARY	222,736	36,797	0	17,780	0
17.00	01700	SOCIAL SERVICE	337,937	23,282	0	11,250	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,047,766	668,692	281,226	323,105	654,431
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	130,624	5,607	0	2,709	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	110,446	23,990	0	11,592	0
60.00	06000	LABORATORY	173,828	29,331	0	14,173	0
65.00	06500	RESPIRATORY THERAPY	653,745	37,771	0	18,251	0
66.00	06600	PHYSICAL THERAPY	395,652	28,033	0	13,545	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	88,513	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	436,905	0	0	0	0
74.00	07400	RENAL DIALYSIS	190,262	22,721	0	10,979	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,785,263	1,260,865	281,226	580,497	1,255,943
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	NONALLOWABLE CLINICAL LIAISON	19,983	0	0	0	0
194.01	07951	IDLE SPACE	0	0	0	0	0
194.02	07952	REGIONAL OFFICE	0	0	0	0	0
194.03	07953	DISTRICT OFFICE	0	0	0	0	0
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0
194.05	07955	REG NURSG OFFICE	0	0	0	0	0
194.06	07956	CONTACT CENTER	0	0	0	0	0
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	0
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0
194.09	07958	VISITOR MEALS	0	0	0	0	43,777
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	7,805,246	1,260,865	281,226	580,497	1,299,720

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-2010

Period:
From 09/01/2017
To 08/31/2018

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	686,555					11.00
13.00	01300	75,789	2,657,457				13.00
14.00	01400	13,374	0	744,208			14.00
15.00	01500	31,207	0	17,712	1,993,928		15.00
16.00	01600	31,207	0	1,335	0	1,004,356	16.00
17.00	01700	44,581	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	374,486	2,565,821	404,635	337	420,452	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	13,374	91,636	0	0	5,062	50.00
54.00	05400	4,458	0	0	0	16,742	54.00
60.00	06000	4,458	0	8,070	0	90,710	60.00
65.00	06500	93,621	0	119,826	0	257,197	65.00
66.00	06600	0	0	18,475	0	39,212	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	0	174,155	0	9,895	71.00
73.00	07300	0	0	0	1,993,591	151,279	73.00
74.00	07400	0	0	0	0	13,807	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
98.00	09850	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		686,555	2,657,457	744,208	1,993,928	1,004,356	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		686,555	2,657,457	744,208	1,993,928	1,004,356	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-2010

Period:
From 09/01/2017
To 08/31/2018

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Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	1,470,753			17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,470,753	19,714,749	0	19,714,749
31.00	03100	INTENSIVE CARE UNIT	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	656,302	0	656,302
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	511,603	0	511,603
60.00	06000	LABORATORY	0	862,574	0	862,574
65.00	06500	RESPIRATORY THERAPY	0	3,218,817	0	3,218,817
66.00	06600	PHYSICAL THERAPY	0	1,728,577	0	1,728,577
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	548,549	0	548,549
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,944,065	0	3,944,065
74.00	07400	RENAL DIALYSIS	0	831,014	0	831,014
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,470,753	32,016,250	0	32,016,250
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	82,292	0	82,292
194.01	07951	IDLE SPACE	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	194.05
194.06	07956	CONTACT CENTER	0	0	0	194.06
194.07	07957	CENTRALIZED ADMINISTRATIONS DEPT	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	43,777	0	43,777
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	194.11
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,470,753	32,142,319	0	32,142,319

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-2010

Period:
From 09/01/2017
To 08/31/2018

Worksheet B
Part II
Date/Time Prepared:
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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	6,548	2,551	9,099	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	228,059	382,738	149,084	759,881	5.00
7.00 00700	OPERATION OF PLANT	0	120,136	46,795	166,931	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	49,742	19,375	69,117	8.00
9.00 00900	HOUSEKEEPING	0	34,882	13,587	48,469	9.00
10.00 01000	DIETARY	0	78,286	30,494	108,780	10.00
11.00 01100	CAFETERIA	0	29,551	11,511	41,062	11.00
13.00 01300	NURSING ADMINISTRATION	0	74,550	29,039	103,589	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	139,613	54,382	193,995	14.00
15.00 01500	PHARMACY	0	140,536	54,742	195,278	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	52,344	20,389	72,733	16.00
17.00 01700	SOCIAL SERVICE	0	33,119	12,901	46,020	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	951,222	370,520	1,321,742	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	7,975	3,107	11,082	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	34,127	13,293	47,420	54.00
60.00 06000	LABORATORY	0	41,724	16,252	57,976	60.00
65.00 06500	RESPIRATORY THERAPY	0	53,729	20,929	74,658	65.00
66.00 06600	PHYSICAL THERAPY	0	39,877	15,533	55,410	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	32,322	12,590	44,912	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00 09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	228,059	2,303,021	897,074	3,428,154	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	NONALLOWABLE CLINICAL LIAISON	0	0	0	0	194.00
194.01 07951	IDLE SPACE	0	0	0	0	194.01
194.02 07952	REGIONAL OFFICE	0	0	0	0	194.02
194.03 07953	DISTRICT OFFICE	0	0	0	0	194.03
194.04 07954	NON MCR CERTIFIED UNIT	0	0	0	0	194.04
194.05 07955	REG NURSG OFFICE	0	0	0	0	194.05
194.06 07956	CONTACT CENTER	0	0	0	0	194.06
194.07 07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	194.07
194.08 07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.08
194.09 07958	VISITOR MEALS	0	0	0	0	194.09
194.10 07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.10
194.11 07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	228,059	2,303,021	897,074	3,428,154	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 26-2010		Period: From 09/01/2017 To 08/31/2018		Worksheet B Part II Date/Time Prepared: 12/13/2018 9:20 am	
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	761,188				5.00
7.00	00700	OPERATION OF PLANT	29,860	196,791			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,832	5,458	80,407		8.00
9.00	00900	HOUSEKEEPING	13,167	3,827	0	65,634	9.00
10.00	01000	DIETARY	28,847	8,589	0	3,007	149,322
11.00	01100	CAFETERIA	1,284	3,242	0	1,135	69,106
13.00	01300	NURSING ADMINISTRATION	59,298	8,179	0	2,863	0
14.00	01400	CENTRAL SERVICES & SUPPLY	13,860	15,318	0	5,362	0
15.00	01500	PHARMACY	42,591	15,419	0	5,397	0
16.00	01600	MEDICAL RECORDS & LIBRARY	21,722	5,743	0	2,010	0
17.00	01700	SOCIAL SERVICE	32,957	3,634	0	1,272	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	297,224	104,369	80,407	36,532	75,187
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	12,739	875	0	306	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,771	3,744	0	1,311	0
60.00	06000	LABORATORY	16,952	4,578	0	1,602	0
65.00	06500	RESPIRATORY THERAPY	63,755	5,895	0	2,064	0
66.00	06600	PHYSICAL THERAPY	38,585	4,375	0	1,532	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,632	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	42,608	0	0	0	0
74.00	07400	RENAL DIALYSIS	18,555	3,546	0	1,241	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	759,239	196,791	80,407	65,634	144,293
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	NONALLOWABLE CLINICAL LIAISON	1,949	0	0	0	0
194.01	07951	IDLE SPACE	0	0	0	0	0
194.02	07952	REGIONAL OFFICE	0	0	0	0	0
194.03	07953	DISTRICT OFFICE	0	0	0	0	0
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0
194.05	07955	REG NURSG OFFICE	0	0	0	0	0
194.06	07956	CONTACT CENTER	0	0	0	0	0
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	0
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0
194.09	07958	VISITOR MEALS	0	0	0	0	5,029
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	761,188	196,791	80,407	65,634	149,322

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 26-2010	Period: From 09/01/2017 To 08/31/2018	Worksheet B Part II Date/Time Prepared: 12/13/2018 9:20 am
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	115,829					11.00
13.00	01300	12,786	187,849				13.00
14.00	01400	2,256	0	230,868			14.00
15.00	01500	5,265	0	5,495	269,905		15.00
16.00	01600	5,265	0	414	0	108,225	16.00
17.00	01700	7,521	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	63,181	181,371	125,526	46	45,287	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	2,256	6,478	0	0	546	50.00
54.00	05400	752	0	0	0	1,805	54.00
60.00	06000	752	0	2,504	0	9,777	60.00
65.00	06500	15,795	0	37,172	0	27,722	65.00
66.00	06600	0	0	5,731	0	4,227	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	0	54,026	0	1,067	71.00
73.00	07300	0	0	0	269,859	16,306	73.00
74.00	07400	0	0	0	0	1,488	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
98.00	09850	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		115,829	187,849	230,868	269,905	108,225	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		115,829	187,849	230,868	269,905	108,225	202.00

ALLOCATION OF CAPITAL RELATED COSTS				Provider CCN: 26-2010	Period: From 09/01/2017 To 08/31/2018	Worksheet B Part II Date/Time Prepared: 12/13/2018 9:20 am
Cost Center	Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	92,015			17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	92,015	2,426,459	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	34,448	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	65,858	0	54.00
60.00	06000	LABORATORY	0	94,201	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	228,072	0	65.00
66.00	06600	PHYSICAL THERAPY	0	109,860	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	63,725	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	328,773	0	73.00
74.00	07400	RENAL DIALYSIS	0	69,742	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	92,015	3,421,138	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	1,987	0	194.00
194.01	07951	IDLE SPACE	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	194.05
194.06	07956	CONTACT CENTER	0	0	0	194.06
194.07	07957	CENTRALIZED ADMINISTRATIONS DEPT	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	5,029	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	194.11
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	92,015	3,428,154	0	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-2010

Period:
From 09/01/2017
To 08/31/2018

Worksheet B-1
Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET #1)	MVBLE EQUIP (SQUARE FEET #2)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	54,865				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		54,865			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	156	156	12,194,815		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	9,118	9,118	1,751,907	-7,805,246	5.00
7.00 00700	OPERATION OF PLANT	2,862	2,862	0	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,185	1,185	0	0	8.00
9.00 00900	HOUSEKEEPING	831	831	229,364	0	9.00
10.00 01000	DIETARY	1,865	1,865	133,311	0	10.00
11.00 01100	CAFETERIA	704	704	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	1,776	1,776	1,519,849	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	3,326	3,326	103,376	0	14.00
15.00 01500	PHARMACY	3,348	3,348	616,809	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,247	1,247	453,738	0	16.00
17.00 01700	SOCIAL SERVICE	789	789	818,940	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	22,661	22,661	4,784,357	0	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	190	190	221,972	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	813	813	74,247	0	54.00
60.00 06000	LABORATORY	994	994	80,586	0	60.00
65.00 06500	RESPIRATORY THERAPY	1,280	1,280	1,355,815	0	65.00
66.00 06600	PHYSICAL THERAPY	950	950	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
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	770	770	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00 09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	54,865	54,865	12,144,271	-7,805,246	24,274,764
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	NONALLOWABLE CLINICAL LIAISON	0	0	50,544	0	194.00
194.01 07951	IDLE SPACE	0	0	0	0	194.01
194.02 07952	REGIONAL OFFICE	0	0	0	0	194.02
194.03 07953	DISTRICT OFFICE	0	0	0	0	194.03
194.04 07954	NON MCR CERTIFIED UNIT	0	0	0	0	194.04
194.05 07955	REG NURSG OFFICE	0	0	0	0	194.05
194.06 07956	CONTACT CENTER	0	0	0	0	194.06
194.07 07957	CENTRALIZED ADMINISTRATIONS DEPT	0	0	0	0	194.07
194.08 07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.08
194.09 07958	VISITOR MEALS	0	0	0	0	194.09
194.10 07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.10
194.11 07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,303,021	897,074	2,067,138		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	41.976141	16.350570	0.169510		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			9,099		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000746		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: 26-2010

Period:
From 09/01/2017
To 08/31/2018

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		OPERATION OF PLANT (SQUARE FEET #3)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET #4)	DIETARY (MEALS SERVED)	CAFETERIA (CAFETERIA FTES)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	42,729				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,185	19,478			8.00
9.00	00900	HOUSEKEEPING	831	0	40,713		9.00
10.00	01000	DIETARY	1,865	0	1,865	34,410	10.00
11.00	01100	CAFETERIA	704	0	704	15,925	154
13.00	01300	NURSING ADMINISTRATION	1,776	0	1,776	0	17
14.00	01400	CENTRAL SERVICES & SUPPLY	3,326	0	3,326	0	3
15.00	01500	PHARMACY	3,348	0	3,348	0	7
16.00	01600	MEDICAL RECORDS & LIBRARY	1,247	0	1,247	0	7
17.00	01700	SOCIAL SERVICE	789	0	789	0	10
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	22,661	19,478	22,661	17,326	84
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	190	0	190	0	3
54.00	05400	RADIOLOGY-DIAGNOSTIC	813	0	813	0	1
60.00	06000	LABORATORY	994	0	994	0	1
65.00	06500	RESPIRATORY THERAPY	1,280	0	1,280	0	21
66.00	06600	PHYSICAL THERAPY	950	0	950	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	770	0	770	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	42,729	19,478	40,713	33,251	154
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	0	0	0	0
194.01	07951	IDLE SPACE	0	0	0	0	0
194.02	07952	REGIONAL OFFICE	0	0	0	0	0
194.03	07953	DISTRICT OFFICE	0	0	0	0	0
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0
194.05	07955	REG NURSG OFFICE	0	0	0	0	0
194.06	07956	CONTACT CENTER	0	0	0	0	0
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	0
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0
194.09	07958	VISITOR MEALS	0	0	0	1,159	0
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,260,865	281,226	580,497	1,299,720	686,555
203.00		Unit cost multiplier (Wkst. B, Part I)	29.508413	14.438135	14.258271	37.771578	4,458.149351
204.00		Cost to be allocated (per Wkst. B, Part II)	196,791	80,407	65,634	149,322	115,829
205.00		Unit cost multiplier (Wkst. B, Part II)	4.605561	4.128093	1.612114	4.339494	752.136364
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: 26-2010

Period:
From 09/01/2017
To 08/31/2018

Worksheet B-1
Date/Time Prepared:
12/13/2018 9:20 am

Cost Center Description		NURSING ADMINISTRATION (NURSING FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	87					13.00
14.00	01400	0	1,179,359				14.00
15.00	01500	0	28,069	1,362,520			15.00
16.00	01600	0	2,116	0	144,541,731		16.00
17.00	01700	0	0	0	0	19,478	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	84	641,231	230	60,514,472	19,478	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	3	0	0	728,436	0	50.00
54.00	05400	0	0	0	2,409,253	0	54.00
60.00	06000	0	12,789	0	13,053,714	0	60.00
65.00	06500	0	189,890	0	37,012,109	0	65.00
66.00	06600	0	29,278	0	5,642,887	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	275,986	0	1,423,989	0	71.00
73.00	07300	0	0	1,362,290	21,769,938	0	73.00
74.00	07400	0	0	0	1,986,933	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
98.00	09850	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		87	1,179,359	1,362,520	144,541,731	19,478	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
200.00							200.00
201.00							201.00
202.00		2,657,457	744,208	1,993,928	1,004,356	1,470,753	202.00
203.00		30,545.482759	0.631028	1.463412	0.006949	75.508420	203.00
204.00		187,849	230,868	269,905	108,225	92,015	204.00
205.00		2,159.183908	0.195757	0.198093	0.000749	4.724048	205.00
206.00							206.00
207.00							207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-2010

Period:
From 09/01/2017
To 08/31/2018

Worksheet C
Part I
Date/Time Prepared:
12/13/2018 9:20 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE	Total Costs	
					Disallowance		
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	19,714,749		19,714,749	14,299	19,729,048	30.00
31.00	03100 INTENSIVE CARE UNIT	0		0	0	0	31.00
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	656,302		656,302	0	656,302	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	511,603		511,603	726	512,329	54.00
60.00	06000 LABORATORY	862,574		862,574	0	862,574	60.00
65.00	06500 RESPIRATORY THERAPY	3,218,817	0	3,218,817	909	3,219,726	65.00
66.00	06600 PHYSICAL THERAPY	1,728,577	0	1,728,577	0	1,728,577	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	548,549		548,549	0	548,549	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,944,065		3,944,065	0	3,944,065	73.00
74.00	07400 RENAL DIALYSIS	831,014		831,014	624	831,638	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0		0	0	0	90.00
91.00	09100 EMERGENCY	0		0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0		0	0	0	95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
200.00	Subtotal (see instructions)	32,016,250	0	32,016,250	16,558	32,032,808	200.00
201.00	Less Observation Beds	0		0	0	0	201.00
202.00	Total (see instructions)	32,016,250	0	32,016,250	16,558	32,032,808	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-2010

Period:
From 09/01/2017
To 08/31/2018

Worksheet C
Part I
Date/Time Prepared:
12/13/2018 9:20 am

		Title XVIII			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	60,514,472		60,514,472		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	722,844	5,592	728,436	0.900974	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,322,424	86,829	2,409,253	0.212349	54.00
60.00	06000	LABORATORY	12,758,770	294,944	13,053,714	0.066079	60.00
65.00	06500	RESPIRATORY THERAPY	36,855,519	156,590	37,012,109	0.086967	65.00
66.00	06600	PHYSICAL THERAPY	5,615,478	27,409	5,642,887	0.306328	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,418,287	5,702	1,423,989	0.385220	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,769,938	0	21,769,938	0.181170	73.00
74.00	07400	RENAL DIALYSIS	1,910,685	76,248	1,986,933	0.418240	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	98.00
200.00		Subtotal (see instructions)	143,888,417	653,314	144,541,731		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	143,888,417	653,314	144,541,731		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 26-2010	Period: From 09/01/2017 To 08/31/2018	Worksheet C Part I Date/Time Prepared: 12/13/2018 9:20 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio	
		11.00	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS		30.00
31.00	03100 INTENSIVE CARE UNIT		31.00
44.00	04400 SKILLED NURSING FACILITY		44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.900974	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.212651	54.00
60.00	06000 LABORATORY	0.066079	60.00
65.00	06500 RESPIRATORY THERAPY	0.086991	65.00
66.00	06600 PHYSICAL THERAPY	0.306328	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.385220	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.181170	73.00
74.00	07400 RENAL DIALYSIS	0.418554	74.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0.000000	90.00
91.00	09100 EMERGENCY	0.000000	91.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	0.000000	95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	98.00
200.00	Subtotal (see instructions)		200.00
201.00	Less Observation Beds		201.00
202.00	Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-2010

Period:
From 09/01/2017
To 08/31/2018

Worksheet C
Part I
Date/Time Prepared:
12/13/2018 9:20 am

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	19,714,749		19,714,749	14,299	19,729,048	30.00
31.00	03100 INTENSIVE CARE UNIT	0		0	0	0	31.00
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	656,302		656,302	0	656,302	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	511,603		511,603	726	512,329	54.00
60.00	06000 LABORATORY	862,574		862,574	0	862,574	60.00
65.00	06500 RESPIRATORY THERAPY	3,218,817	0	3,218,817	909	3,219,726	65.00
66.00	06600 PHYSICAL THERAPY	1,728,577	0	1,728,577	0	1,728,577	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	548,549		548,549	0	548,549	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,944,065		3,944,065	0	3,944,065	73.00
74.00	07400 RENAL DIALYSIS	831,014		831,014	624	831,638	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0		0	0	0	90.00
91.00	09100 EMERGENCY	0		0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0		0	0	0	95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
200.00	Subtotal (see instructions)	32,016,250	0	32,016,250	16,558	32,032,808	200.00
201.00	Less Observation Beds	0		0	0	0	201.00
202.00	Total (see instructions)	32,016,250	0	32,016,250	16,558	32,032,808	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-2010

Period:
From 09/01/2017
To 08/31/2018

Worksheet C
Part I
Date/Time Prepared:
12/13/2018 9:20 am

		Title XIX			Hospital	Cost		
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
		6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	60,514,472		60,514,472			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	722,844	5,592	728,436	0.900974	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,322,424	86,829	2,409,253	0.212349	0.000000	54.00
60.00	06000	LABORATORY	12,758,770	294,944	13,053,714	0.066079	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	36,855,519	156,590	37,012,109	0.086967	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,615,478	27,409	5,642,887	0.306328	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,418,287	5,702	1,423,989	0.385220	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,769,938	0	21,769,938	0.181170	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,910,685	76,248	1,986,933	0.418240	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
200.00		Subtotal (see instructions)	143,888,417	653,314	144,541,731			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	143,888,417	653,314	144,541,731			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 26-2010	Period: From 09/01/2017 To 08/31/2018	Worksheet C Part I Date/Time Prepared: 12/13/2018 9:20 am
		Title XIX	Hospital	Cost

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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 26-2010		Period: From 09/01/2017 To 08/31/2018		Worksheet D Part I Date/Time Prepared: 12/13/2018 9:20 am	
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)	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	2,426,459	0	2,426,459	19,478	124.57	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	2,426,459		2,426,459	19,478		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	8,732	1,087,745				
31.00	INTENSIVE CARE UNIT	0	0				
44.00	SKILLED NURSING FACILITY	0	0				
200.00	Total (lines 30 through 199)	8,732	1,087,745				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 26-2010	Period: From 09/01/2017 To 08/31/2018	Worksheet D Part II Date/Time Prepared: 12/13/2018 9:20 am
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Cost Center Description		Title XVIII			Hospital	PPS	
		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	34,448	728,436	0.047290	276,371	13,070	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	65,858	2,409,253	0.027335	1,049,682	28,693	54.00
60.00	06000 LABORATORY	94,201	13,053,714	0.007216	6,296,926	45,439	60.00
65.00	06500 RESPIRATORY THERAPY	228,072	37,012,109	0.006162	14,719,730	90,703	65.00
66.00	06600 PHYSICAL THERAPY	109,860	5,642,887	0.019469	2,694,661	52,462	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	63,725	1,423,989	0.044751	616,498	27,589	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	328,773	21,769,938	0.015102	10,836,182	163,648	73.00
74.00	07400 RENAL DIALYSIS	69,742	1,986,933	0.035100	920,543	32,311	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0	0	0.000000	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00	Total (lines 50 through 199)	994,679	84,027,259		37,410,593	453,915	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 26-2010	Period: From 09/01/2017 To 08/31/2018	Worksheet D Part III Date/Time Prepared: 12/13/2018 9:20 am
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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	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00	
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	19,478	0.00	8,732 30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0.00	0 31.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0.00	0 44.00	
200.00		Total (lines 30 through 199)	0	0	19,478	0.00	8,732 200.00	
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
44.00	04400	SKILLED NURSING FACILITY	0					44.00
200.00		Total (lines 30 through 199)	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 26-2010	Period: From 09/01/2017 To 08/31/2018	Worksheet D Part IV Date/Time Prepared: 12/13/2018 9:20 am
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Cost Center Description	Title XVIII				Hospital		PPS
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
	1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
60.00 06000 LABORATORY	0	0	0	0	0	60.00	
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00	
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00	
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	0	0	0	0	0	90.00	
91.00 09100 EMERGENCY	0	0	0	0	0	91.00	
OTHER REIMBURSABLE COST CENTERS							
95.00 09500 AMBULANCE SERVICES						95.00	
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00	
200.00 Total (lines 50 through 199)	0	0	0	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 26-2010	Period: From 09/01/2017 To 08/31/2018	Worksheet D Part IV Date/Time Prepared: 12/13/2018 9:20 am
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Cost Center Description		Title XVIII			Hospital	PPS	
		All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 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	728,436	0.000000	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	2,409,253	0.000000	54.00
60.00	06000 LABORATORY	0	0	0	13,053,714	0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	37,012,109	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	5,642,887	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,423,989	0.000000	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	21,769,938	0.000000	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	1,986,933	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0.000000	90.00
91.00	09100 EMERGENCY	0	0	0	0	0.000000	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0.000000	95.00
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	84,027,259		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 26-2010	Period: From 09/01/2017 To 08/31/2018	Worksheet D Part IV Date/Time Prepared: 12/13/2018 9:20 am
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Cost Center Description		Title XVIII			Hospital		PPS
		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	276,371	0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	1,049,682	0	0	0	54.00
60.00	06000 LABORATORY	0.000000	6,296,926	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	14,719,730	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	2,694,661	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	616,498	0	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	10,836,182	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	920,543	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00	Total (Lines 50 through 199)		37,410,593	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 26-2010	Period: From 09/01/2017 To 08/31/2018	Worksheet D Part V Date/Time Prepared: 12/13/2018 9:20 am
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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	0.900974	0	0	0	0
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.212349	0	70,675	0	0
60.00	06000 LABORATORY	0.066079	0	164	0	0
65.00	06500 RESPIRATORY THERAPY	0.086967	0	135,564	0	0
66.00	06600 PHYSICAL THERAPY	0.306328	0	0	0	0
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.385220	0	5,419	0	0
73.00	07300 DRUGS CHARGED TO PATIENTS	0.181170	0	0	0	0
74.00	07400 RENAL DIALYSIS	0.418240	0	69,188	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0.000000	0	0	0	0
91.00	09100 EMERGENCY	0.000000	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	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	281,010	0	0
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0
202.00	Net Charges (line 200 - line 201)		0	281,010	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 26-2010	Period: From 09/01/2017 To 08/31/2018	Worksheet D Part V Date/Time Prepared: 12/13/2018 9:20 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	15,008	0	54.00
60.00	06000 LABORATORY	11	0	60.00
65.00	06500 RESPIRATORY THERAPY	11,790	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,088	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	28,937	0	74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0		95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	98.00
200.00	Subtotal (see instructions)	57,834	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	57,834	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-2010	Period: From 09/01/2017 To 08/31/2018	Worksheet D-1 Date/Time Prepared: 12/13/2018 9:20 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		19,478	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		19,478	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)		19,478	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)		8,732	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)		19,729,048	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)		19,729,048	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)		19,729,048	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,012.89	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		8,844,555	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)		8,844,555	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 26-2010	Period: From 09/01/2017 To 08/31/2018	Worksheet D-1 Date/Time Prepared: 12/13/2018 9:20 am
Title XVIII			Hospital		PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					5,580,223 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					14,424,778 49.00
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,087,745 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					453,915 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,541,660 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					12,883,118 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0 54.00
55.00 Target amount per discharge					0.00 55.00
56.00 Target amount (line 54 x line 55)					0 56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00 Bonus payment (see instructions)					0 58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00 Relief payment (see instructions)					0 62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					0 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-2010		Period: From 09/01/2017 To 08/31/2018		Worksheet D-1 Date/Time Prepared: 12/13/2018 9:20 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,426,459	19,729,048	0.122989	0	0	90.00
91.00	Nursing School cost	0	19,729,048	0.000000	0	0	91.00
92.00	Allied health cost	0	19,729,048	0.000000	0	0	92.00
93.00	All other Medical Education	0	19,729,048	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-2010	Period: From 09/01/2017 To 08/31/2018	Worksheet D-1 Date/Time Prepared: 12/13/2018 9:20 am
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			19,478 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			19,478 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)			19,478 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)			1,726 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)			19,714,749 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)			19,714,749 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)			19,714,749 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,012.15 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,746,971 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)			1,746,971 41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 26-2010	Period: From 09/01/2017 To 08/31/2018	Worksheet D-1 Date/Time Prepared: 12/13/2018 9:20 am
Title XIX			Hospital		Cost
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,746,971
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)					0
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-2010		Period: From 09/01/2017 To 08/31/2018		Worksheet D-1 Date/Time Prepared: 12/13/2018 9:20 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,426,459	19,714,749	0.123078	0	0	90.00
91.00	Nursing School cost	0	19,714,749	0.000000	0	0	91.00
92.00	Allied health cost	0	19,714,749	0.000000	0	0	92.00
93.00	All other Medical Education	0	19,714,749	0.000000	0	0	93.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 26-2010

Period:
From 09/01/2017
To 08/31/2018

Worksheet D-2
Date/Time Prepared:
12/13/2018 9:20 am

Cost Center Description	Percent of Assigned Time	Expense Allocation	Total Inpatient Day All Patients	Average Cost Per Day	Health Care Program Inpatient Days Title V															
	1.00	2.00	3.00	4.00	5.00															
PART I - NOT IN APPROVED TEACHING PROGRAM																				
Hospital Inpatient Routine Services:																				
1.00 Total cost of services rendered	0.00	0				1.00														
2.00 ADULTS & PEDIATRICS	0.00	0	19,478	0.00	0	2.00														
3.00 INTENSIVE CARE UNIT	0.00	0	0	0.00	0	3.00														
4.00 CORONARY CARE UNIT						4.00														
5.00 BURN INTENSIVE CARE UNIT						5.00														
6.00 SURGICAL INTENSIVE CARE UNIT						6.00														
7.00 OTHER SPECIAL CARE (SPECIFY)						7.00														
8.00 NURSERY						8.00														
9.00 Subtotal (sum of lines 2 through 8)	0.00	0				9.00														
10.00 SUBPROVIDER - IPF						10.00														
11.00 SUBPROVIDER - IRF						11.00														
12.00 SUBPROVIDER						12.00														
13.00 SKILLED NURSING FACILITY	0.00	0	0	0.00	0	13.00														
14.00 NURSING FACILITY						14.00														
15.00 OTHER LONG TERM CARE						15.00														
16.00 HOME HEALTH AGENCY						16.00														
17.00 CMHC						17.00														
18.00 AMBULATORY SURGICAL CENTER (D.P.)						18.00														
19.00 HOSPICE						19.00														
20.00 Subtotal (sum of lines 9 through 19)	0.00	0				20.00														
<table border="1"> <thead> <tr> <th>Cost Center Description</th> <th></th> <th></th> <th>Total Charges (from Worksheet C, Part I, column 8, lines 88 through 93)</th> <th>Ratio of Cost to Charges (col. 2 ÷ col. 3)</th> <th>Titles V and XIX Outpatient and Title XVIII Part B Charges Title V</th> <th></th> </tr> <tr> <td></td> <td>1.00</td> <td>2.00</td> <td>3.00</td> <td>4.00</td> <td>5.00</td> <td></td> </tr> </thead> </table>							Cost Center Description			Total Charges (from Worksheet C, Part I, column 8, lines 88 through 93)	Ratio of Cost to Charges (col. 2 ÷ col. 3)	Titles V and XIX Outpatient and Title XVIII Part B Charges Title V			1.00	2.00	3.00	4.00	5.00	
Cost Center Description			Total Charges (from Worksheet C, Part I, column 8, lines 88 through 93)	Ratio of Cost to Charges (col. 2 ÷ col. 3)	Titles V and XIX Outpatient and Title XVIII Part B Charges Title V															
	1.00	2.00	3.00	4.00	5.00															
Hospital Outpatient Services:																				
21.00 RURAL HEALTH CLINIC						21.00														
22.00 FEDERALLY QUALIFIED HEALTH CENTER						22.00														
23.00 CLINIC	0.00	0	0	0.000000	0	23.00														
24.00 EMERGENCY	0.00	0	0	0.000000	0	24.00														
25.00 OBSERVATION BEDS (NON-DISTINCT PART)						25.00														
26.00 OTHER OUTPATIENT SERVICE COST CENTER						26.00														
27.00 Subtotal (sum of lines 21 through 26)	0.00	0				27.00														
28.00 Total (sum of lines 20 and 27)	0.00	0				28.00														
<table border="1"> <thead> <tr> <th>Cost Center Description</th> <th>Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22</th> <th>Swing bed Amount</th> <th>Net cost (column 1 plus column 2)</th> <th>Total Inpatient Days - All Patients</th> <th>Average Cost Per Day (col. 3 ÷ col. 4)</th> <th></th> </tr> <tr> <td></td> <td>1.00</td> <td>2.00</td> <td>3.00</td> <td>4.00</td> <td>5.00</td> <td></td> </tr> </thead> </table>							Cost Center Description	Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22	Swing bed Amount	Net cost (column 1 plus column 2)	Total Inpatient Days - All Patients	Average Cost Per Day (col. 3 ÷ col. 4)			1.00	2.00	3.00	4.00	5.00	
Cost Center Description	Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22	Swing bed Amount	Net cost (column 1 plus column 2)	Total Inpatient Days - All Patients	Average Cost Per Day (col. 3 ÷ col. 4)															
	1.00	2.00	3.00	4.00	5.00															
PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)																				
Hospital Inpatient Routine Services:																				
29.00 ADULTS & PEDIATRICS	0	0	0	19,478	0.00	29.00														
30.00 Swing Bed - SNF				0	0.00	30.00														
31.00 Swing Bed - NF				0		31.00														
32.00 INTENSIVE CARE UNIT	0			0	0.00	32.00														
33.00 CORONARY CARE UNIT						33.00														
34.00 BURN INTENSIVE CARE UNIT						34.00														
35.00 SURGICAL INTENSIVE CARE UNIT						35.00														
36.00 OTHER SPECIAL CARE (SPECIFY)						36.00														
37.00 Subtotal (sum of lines 29, and 32 through 36)	0			0		37.00														
38.00 SUBPROVIDER - IPF						38.00														
39.00 SUBPROVIDER - IRF						39.00														
40.00 SUBPROVIDER						40.00														
41.00 SKILLED NURSING FACILITY	0			0	0.00	41.00														
42.00 Total (sum of lines 37 through 41)	0			0		42.00														

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 26-2010

Period:
From 09/01/2017
To 08/31/2018

Worksheet D-2

Date/Time Prepared:
12/13/2018 9:20 am

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

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS	Provider CCN: 26-2010	Period: From 09/01/2017 To 08/31/2018	Worksheet D-2 Date/Time Prepared: 12/13/2018 9:20 am
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Cost Center Description	Health Care Program Inpatient Days		Title V (col. 4 x col. 5)	Title XVIII (col. 4 x col. 6)	Title XIX (col. 4 x col. 7)	
	Title XVIII, Part B Only Less Part A Coverage but no Part B Coverage	Title XIX				
	6.00	7.00				
PART I - NOT IN APPROVED TEACHING PROGRAM						
1.00 Total cost of services rendered						1.00
Hospital Inpatient Routine Services:						
2.00 ADULTS & PEDIATRICS	8,732	1,726	0	0	0	2.00
3.00 INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00 CORONARY CARE UNIT						4.00
5.00 BURN INTENSIVE CARE UNIT						5.00
6.00 SURGICAL INTENSIVE CARE UNIT						6.00
7.00 OTHER SPECIAL CARE (SPECIFY)						7.00
8.00 NURSERY						8.00
9.00 Subtotal (sum of lines 2 through 8)			0	0	0	9.00
10.00 SUBPROVIDER - IPF						10.00
11.00 SUBPROVIDER - IRF						11.00
12.00 SUBPROVIDER						12.00
13.00 SKILLED NURSING FACILITY	0	0	0	0	0	13.00
14.00 NURSING FACILITY						14.00
15.00 OTHER LONG TERM CARE						15.00
16.00 HOME HEALTH AGENCY						16.00
17.00 CMHC						17.00
18.00 AMBULATORY SURGICAL CENTER (D.P.)						18.00
19.00 HOSPICE						19.00
20.00 Subtotal (sum of lines 9 through 19)						20.00
Cost Center Description		Titles V and XIX Outpatient and Title XVIII Part B Charges		Titles V and XIX Outpatient and Title XVIII Part B Cost		
		Title XVIII Part B	Title XIX	Title V	Title XVIII Part B	Title XIX
		6.00	7.00	8.00	9.00	10.00
Hospital Outpatient Services:						
21.00 RURAL HEALTH CLINIC						21.00
22.00 FEDERALLY QUALIFIED HEALTH CENTER						22.00
23.00 CLINIC	0	0	0	0	0	23.00
24.00 EMERGENCY	0	0	0	0	0	24.00
25.00 OBSERVATION BEDS (NON-DISTINCT PART)						25.00
26.00 OTHER OUTPATIENT SERVICE COST CENTER						26.00
27.00 Subtotal (sum of lines 21 through 26)			0	0	0	27.00
28.00 Total (sum of lines 20 and 27)						28.00
Cost Center Description		Title XVIII Part B Inpatient Days	Expenses Applicable to Title XVIII (col. 5 x col. 6)	PSA Adj. Interns & Residents		
		6.00	7.00	11.00		
PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)						
Hospital Inpatient Routine Services:						
29.00 ADULTS & PEDIATRICS	0	0	0			29.00
30.00 Swing Bed - SNF	0	0				30.00
31.00 Swing Bed - NF						31.00
32.00 INTENSIVE CARE UNIT	0	0	0			32.00
33.00 CORONARY CARE UNIT						33.00
34.00 BURN INTENSIVE CARE UNIT						34.00
35.00 SURGICAL INTENSIVE CARE UNIT						35.00
36.00 OTHER SPECIAL CARE (SPECIFY)						36.00
37.00 Subtotal (sum of lines 29, and 32 through 36)		0	0			37.00
38.00 SUBPROVIDER - IPF						38.00
39.00 SUBPROVIDER - IRF						39.00
40.00 SUBPROVIDER						40.00
41.00 SKILLED NURSING FACILITY	0	0	0			41.00
42.00 Total (sum of lines 37 through 41)		0	0			42.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS	Provider CCN: 26-2010	Period: From 09/01/2017 To 08/31/2018	Worksheet D-2 Date/Time Prepared: 12/13/2018 9:20 am
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Cost Center Description	In Approved Teaching Program	Total Title XVIII Costs			
	Amount	(to Wkst. E, Part B -)	(col. 2 + col. 4)		
	4.00	5.00	6.00		
PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED)					
Hospital					
43.00	Inpatient	0		0	43.00
44.00	Outpatient				44.00
45.00	Total Hospital (sum of lines 43 and 44)	0	line 22	0	45.00
46.00	SUBPROVIDER - IPF				46.00
47.00	SUBPROVIDER - IRF				47.00
48.00	SUBPROVIDER				48.00
49.00	SKILLED NURSING FACILITY	0	line 22	0	49.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 26-2010	Period: From 09/01/2017 To 08/31/2018	Worksheet D-3 Date/Time Prepared: 12/13/2018 9:20 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
Title XVIII Hospital PPS					
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		27,099,891	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.900974	276,371	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.212651	1,049,682	54.00
60.00	06000	LABORATORY	0.066079	6,296,926	60.00
65.00	06500	RESPIRATORY THERAPY	0.086991	14,719,730	65.00
66.00	06600	PHYSICAL THERAPY	0.306328	2,694,661	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.385220	616,498	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.181170	10,836,182	73.00
74.00	07400	RENAL DIALYSIS	0.418554	920,543	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
91.00	09100	EMERGENCY	0.000000	0	91.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		37,410,593	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		37,410,593	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-2010	Period: From 09/01/2017 To 08/31/2018	Worksheet E Part B Date/Time Prepared: 12/13/2018 9:20 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		57,834	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)		57,834	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		281,010	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)		281,010	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)		281,010	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		223,176	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)		57,834	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 amounts (for CAH, see instructions)		56,202	25.00
26.00	Deductibles and Coinsurance amounts 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)		1,632	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		1,632	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,632	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		1,632	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		1,632	40.00
40.01	Sequestration adjustment (see instructions)		33	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		12,672	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-11,073	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 26-2010		Period: From 09/01/2017 To 08/31/2018		Worksheet E-1 Part I Date/Time Prepared: 12/13/2018 9:20 am	
		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		13,573,572		12,672	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	11/30/2017	127,400		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)		127,400		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)		13,700,972		12,672	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		742,534		11,073	6.02	
7.00	Total Medicare program liability (see instructions)		12,958,438		1,599	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-2010	Period: From 09/01/2017 To 08/31/2018	Worksheet E-3 Part IV Date/Time Prepared: 12/13/2018 9:20 am
		Title XVIII	Hospital	PPS
		1.00		
PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)		12,694,981	1.00
1.01	Full standard payment amount		9,155,347	1.01
1.02	Short stay outlier standard payment amount		3,263,336	1.02
1.03	Site neutral payment amount - Cost		6,503	1.03
1.04	Site neutral payment amount - IPPS comparable		269,795	1.04
2.00	Outlier Payments		1,442,117	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)		14,137,098	3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)		0	4.00
5.00	Organ acquisition (DO NOT USE THIS LINE)		0	5.00
6.00	Cost of physicians' services in a teaching hospital (see instructions)		0	6.00
7.00	Subtotal (see instructions)		14,137,098	7.00
8.00	Primary payer payments		0	8.00
9.00	Subtotal (line 7 less line 8)		14,137,098	9.00
10.00	Deductibles		31,848	10.00
11.00	Subtotal (line 9 minus line 10)		14,105,250	11.00
12.00	Coinsurance		1,241,702	12.00
13.00	Subtotal (line 11 minus line 12)		12,863,548	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		552,843	14.00
15.00	Adjusted reimbursable bad debts (see instructions)		359,348	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		395,742	16.00
17.00	Subtotal (sum of lines 13 and 15)		13,222,896	17.00
18.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	18.00
19.00	Other pass through costs (see instructions)		0	19.00
20.00	Outlier payments reconciliation		0	20.00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	21.00
21.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	21.50
21.99	Demonstration payment adjustment amount before sequestration		0	21.99
22.00	Total amount payable to the provider (see instructions)		13,222,896	22.00
22.01	Sequestration adjustment (see instructions)		264,458	22.01
22.02	Demonstration payment adjustment amount after sequestration		0	22.02
23.00	Interim payments		13,700,972	23.00
24.00	Tentative settlement (for contractor use only)		0	24.00
25.00	Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24)		-742,534	25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		12,329	26.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions)		1,442,117	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money (see instructions)		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-2010	Period: From 09/01/2017 To 08/31/2018	Worksheet E-3 Part VII Date/Time Prepared: 12/13/2018 9:20 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		1,746,971		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		1,746,971	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		1,746,971	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		1,746,971	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		1,746,971	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS		0	0	37.00
37.01	OTHER ADJUSTMENTS		0	0	37.01
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0		41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 26-2010

Period:
From 09/01/2017
To 08/31/2018

Worksheet G
Date/Time Prepared:
12/13/2018 9:20 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	76,699	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	9,477,217	0	0	0	4.00
5.00	Other receivable	9,720	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,608,076	0	0	0	6.00
7.00	Inventory	349,714	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	7,305,274	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	3,509,291	0	0	0	17.00
18.00	Accumulated depreciation	-1,953,332	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	6,044,563	0	0	0	23.00
24.00	Accumulated depreciation	-4,821,712	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)	2,778,810	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	10,084,084	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	810,560	0	0	0	37.00
38.00	Salaries, wages, and fees payable	405,291	0	0	0	38.00
39.00	Payroll taxes payable	14,037	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,701,014	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,930,902	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	-91,044	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-91,044	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	2,839,858	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	7,244,226				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)	7,244,226	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	10,084,084	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 26-2010

Period:
From 09/01/2017
To 08/31/2018

Worksheet G-1

Date/Time Prepared:
12/13/2018 9:20 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		32,770,227		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		2,736,203			2.00
3.00	Total (sum of line 1 and line 2)		35,506,430		0	3.00
4.00	Additions (credit adjustments)	0		0		4.00
5.00	INTERCOMPANY TRANSFERS\ROUNDING	0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		35,506,430		0	11.00
12.00	Deductions (debit adjustments)	0		0		12.00
13.00	INTERCOMPANY TRANSFERS\ROUNDING	28,262,204		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		28,262,204		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		7,244,226		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments)		0			4.00
5.00	INTERCOMPANY TRANSFERS\ROUNDING		0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments)		0			12.00
13.00	INTERCOMPANY TRANSFERS\ROUNDING		0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 26-2010

Period:
From 09/01/2017
To 08/31/2018

Worksheet G-2
Parts I & II
Date/Time Prepared:
12/13/2018 9:20 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	60,514,472		60,514,472	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	60,514,472		60,514,472	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	60,514,472		60,514,472	17.00
18.00	Ancillary services	83,373,945	653,314	84,027,259	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	143,888,417	653,314	144,541,731	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		33,370,878		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)		33,370,878		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 26-2010

Period:
From 09/01/2017
To 08/31/2018

Worksheet G-3

Date/Time Prepared:
12/13/2018 9:20 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	144,541,731	1.00
2.00	Less contractual allowances and discounts on patients' accounts	108,535,880	2.00
3.00	Net patient revenues (line 1 minus line 2)	36,005,851	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	33,370,878	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,634,973	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	8,244	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	526	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	1,202	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	1,628	21.00
22.00	Rental of hospital space	1,567	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	88,063	24.00
25.00	Total other income (sum of lines 6-24)	101,230	25.00
26.00	Total (line 5 plus line 25)	2,736,203	26.00
27.00	OTHER EXPENSES	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,736,203	29.00