

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 26-3304	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/23/2019 12:47 pm
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<b>PART I - COST REPORT STATUS</b>			
Provider use only	1. <input type="checkbox"/> Electronically filed cost report 2. <input checked="" type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/23/2019	Time: 12:47 pm
Contractor use only	5. <input checked="" type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SHC-ST LOUIS ( 26-3304 ) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) \_\_\_\_\_  
 Officer or Administrator of Provider(s)

VICE PRESIDENT FINANCE  
 \_\_\_\_\_  
 Title

\_\_\_\_\_  
 Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	0	0	0	415,869	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
8.00 NURSING FACILITY	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	0	0	0	415,869	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 26-3304		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part I Date/Time Prepared: 5/23/2019 12:47 pm															
1.00		2.00		3.00		4.00																	
Hospital and Hospital Health Care Complex Address:																							
1.00	Street: 4400 CLAYTON AVENUE			PO Box:							1.00												
2.00	City: ST. LOUIS			State: MO		Zip Code: 63110		County:			2.00												
Component Name																							
Component Identification:																							
1.00																							
2.00																							
3.00																							
4.00																							
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15.00																							
16.00																							
17.00																							
17.10																							
18.00																							
19.00																							
3.00	Hospital			SHC-ST LOUIS		263304		41180		7		03/02/2011		N		T		0		3.00			
4.00	Subprovider - IPF																			4.00			
5.00	Subprovider - IRF																			5.00			
6.00	Subprovider - (Other)																			6.00			
7.00	Swing Beds - SNF																			7.00			
8.00	Swing Beds - NF																			8.00			
9.00	Hospital-Based SNF																			9.00			
10.00	Hospital-Based NF																			10.00			
11.00	Hospital-Based OLTC																			11.00			
12.00	Hospital-Based HHA																			12.00			
13.00	Separately Certified ASC																			13.00			
14.00	Hospital-Based Hospice																			14.00			
15.00	Hospital-Based Health Clinic - RHC																			15.00			
16.00	Hospital-Based Health Clinic - FQHC																			16.00			
17.00	Hospital-Based (CMHC) I																			17.00			
17.10	Hospital-Based (CORF) I																			17.10			
18.00	Renal Dialysis																			18.00			
19.00	Other																			19.00			
											From:		To:										
											1.00		2.00										
20.00	Cost Reporting Period (mm/dd/yyyy)										01/01/2018		12/31/2018		20.00								
21.00	Type of Control (see instructions)										2				21.00								
											1.00		2.00		3.00								
Inpatient PPS Information																							
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.										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.										1		N				23.00						
											In-State Medicaid paid days		In-State Medicaid eligible unpaid days		Out-of-State Medicaid paid days		Out-of-State Medicaid eligible unpaid days		Medicaid HMO days		Other Medicaid days		
											1.00		2.00		3.00		4.00		5.00		6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.										0		0		0		0		0		0		24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-3304		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part I Date/Time Prepared: 5/23/2019 12:47 pm			
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0	25.00	
		Urban/Rural		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)							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		XIII		XIX			
		1.00		2.00		3.00			
<b>Prospective Payment System (PPS)-Capital</b>									
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
<b>Teaching Hospitals</b>									
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 Criteria 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	
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>							
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
<b>Teaching Hospitals that Claim Residents in Nonprovider Settings</b>							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
			1.00	2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-3304		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part I Date/Time Prepared: 5/23/2019 12:47 pm	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
					1.00	2.00	3.00
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	76.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-3304	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/23/2019 12:47 pm		
		1.00	2.00			
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00
		1.00	2.00	3.00		
<b>Miscellaneous Cost Reporting Information</b>						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	1	1			118.01
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00
<b>Transplant Center Information</b>						
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
<b>All Providers</b>						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		HB0180		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-3304	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/23/2019 12:47 pm
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		1.00	2.00	3.00				
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.								
141.00	Name: SHRINERS HOSPITALS FOR CHILDREN	Contractor's Name: HBCSO, INC		Contractor's Number: 09101		141.00		
142.00	Street: 2900 ROCKY POINT DRIVE	PO Box:				142.00		
143.00	City: TAMPA	State: FL		Zip Code: 33607		143.00		
						1.00		
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00		
						1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			N		145.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.			N		146.00		
						1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00		
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00		
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00		
				Part A	Part B	Title V	Title XIX	
				1.00	2.00	3.00	4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	N		N		N		
156.00	Subprovider - IPF	N		N		N		
157.00	Subprovider - IRF	N		N		N		
158.00	SUBPROVIDER							
159.00	SNF	N		N		N		
160.00	HOME HEALTH AGENCY	N		N		N		
161.00	CMHC			N		N		
161.10	CORF			N		N		
						1.00		
165.00	Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00		
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00		
						1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00		
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					0168.00		
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01		
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.00		169.00		
						1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					170.00		
						1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)			N		0171.00		

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 26-3304		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part II Date/Time Prepared: 5/23/2019 12:47 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C	05/01/2018			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N	N				6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					1.00
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				N		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				N		14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				N		15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N			N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N			N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N			N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N			N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 26-3304	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/23/2019 12:47 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	NONE	N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	Y	Y		21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
			Y/N	Date	
			1.00	2.00	
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DOUGLAS	BEAL		41.00
42.00	Enter the employer/company name of the cost report preparer.	SHRI NERS HOSPITALS FOR CHILDREN			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	813.281.8610	DBEAL@SHRI NENET.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 26-3304	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/23/2019 12:47 pm
		3.00		
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CORPORATE REIMBURSEMENT DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 26-3304

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/23/2019 12:47 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	12	4,380	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		12	4,380	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00 CORONARY CARE UNIT	32.00	0	0	0.00	0	9.00
10.00 BURN INTENSIVE CARE UNIT	33.00	0	0	0.00	0	10.00
11.00 SURGICAL INTENSIVE CARE UNIT	34.00	0	0	0.00	0	11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		12	4,380	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00 NURSING FACILITY	45.00	0	0		0	20.00
21.00 OTHER LONG TERM CARE	46.00	0	0			21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)	115.00					23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC	99.00				0	25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		12				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 26-3304

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/23/2019 12:47 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents			
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll		
	6.00	7.00	8.00	9.00	10.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	0	27	1,107			1.00
2.00	HMO and other (see instructions)	0	217				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	27	1,107			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			8.00
9.00	CORONARY CARE UNIT	0	0	0			9.00
10.00	BURN INTENSIVE CARE UNIT	0	0	0			10.00
11.00	SURGICAL INTENSIVE CARE UNIT	0	0	0			11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	0			13.00
14.00	Total (see instructions)	0	27	1,107	0.00	150.56	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER	0	0	0	0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY		0	0	0.00	0.00	20.00
21.00	OTHER LONG TERM CARE		0	0	0.00	0.00	21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)				0.00	0.00	23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC	0	0	0	0.00	0.00	25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	150.56	27.00
28.00	Observation Bed Days		0	2			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 26-3304

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/23/2019 12:47 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	0	8	302	1.00
2.00 HMO and other (see instructions)				0	72		2.00
3.00 HMO IPF Subprovider					0		3.00
4.00 HMO IRF Subprovider					0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0	0	0	8	302	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF	0.00	0	0	0	0	0	16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	0	17.00
18.00 SUBPROVIDER	0.00	0	0	0	0	0	18.00
19.00 SKILLED NURSING FACILITY	0.00						19.00
20.00 NURSING FACILITY	0.00						20.00
21.00 OTHER LONG TERM CARE	0.00					0	21.00
22.00 HOME HEALTH AGENCY	0.00						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)	0.00						23.00
24.00 HOSPICE	0.00						24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC	0.00						25.00
25.10 CMHC - CORF	0.00						25.10
26.00 RURAL HEALTH CLINIC	0.00						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00						26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days				0			33.00
33.01 LTCH site neutral days and discharges				0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 26-3304	Period: From 01/01/2018 To 12/31/2018	Worksheet S-10 Date/Time Prepared: 5/23/2019 12:47 pm
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			1.00		
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.516096	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		123,045	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		0	6.00	
7.00	Medicaid cost (line 1 times line 6)		0	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0	8.00	
<b>Children's Health Insurance Program (CHIP) (see instructions for each line)</b>					
9.00	Net revenue from stand-alone CHIP		0	9.00	
10.00	Stand-alone CHIP charges		0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
<b>Other state or local government indigent care program (see instructions for each line)</b>					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
<b>Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)</b>					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00	
			Uninsured patients	Insured patients	Total (col. 1 + col. 2)
			1.00	2.00	3.00
<b>Uncompensated Care (see instructions for each line)</b>					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	10,613,478	0	10,613,478	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	5,477,574	0	5,477,574	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	5,477,574	0	5,477,574	23.00
			1.00		
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		0	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		0	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		0	27.01	
28.00	Non-Medicare bad debt expense (see instructions)		0	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		0	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		5,477,574	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		5,477,574	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 26-3304		Period: From 01/01/2018 To 12/31/2018		Worksheet A	
Date/Time Prepared: 5/23/2019 12:47 pm								
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,783,000	2,783,000	-890,560	1,892,440	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	890,560	890,560	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	246,294	3,266,056	3,512,350	0	3,512,350	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,303,865	1,255,074	2,558,939	-340,873	2,218,066	5.00
7.00	00700	OPERATION OF PLANT	107,199	642,835	750,034	0	750,034	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	72,436	72,436	0	72,436	8.00
9.00	00900	HOUSEKEEPING	227,680	56,534	284,214	0	284,214	9.00
10.00	01000	DIETARY	0	527,557	527,557	0	527,557	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	449,963	10,889	460,852	0	460,852	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	97,851	20,404	118,255	0	118,255	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	150,032	8,565	158,597	0	158,597	16.00
17.00	01700	SOCIAL SERVICE	532,659	9,977	542,636	0	542,636	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	1,091,639	608,858	1,700,497	0	1,700,497	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	04000	SUBPROVIDER - I PF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	638,745	6,872,072	7,510,817	-3,729,886	3,780,931	50.00
51.00	05100	RECOVERY ROOM	537,236	45,870	583,106	0	583,106	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	83,758	1,446,812	1,530,570	0	1,530,570	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	399,190	304,266	703,456	-64,356	639,100	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	197,338	279,019	476,357	-100,426	375,931	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	196,458	5,862	202,320	0	202,320	65.00
66.00	06600	PHYSICAL THERAPY	522,882	5,131	528,013	0	528,013	66.00
67.00	06700	OCCUPATIONAL THERAPY	274,103	8,529	282,632	0	282,632	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	283,158	283,158	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,781,609	3,781,609	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	231,275	199,450	430,725	0	430,725	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	304,535	29,512	334,047	0	334,047	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 26-3304

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

Worksheet A

Date/Time Prepared:  
5/23/2019 12:47 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I & R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,592,702	18,458,708	26,051,410	-170,774	25,880,636	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	1,055,003	3,994,007	5,049,010	0	5,049,010	191.00
191.01	19101	RESEARCH	0	0	0	0	0	191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,526	0	10,526	0	10,526	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ORTHOTICS & PROSTHETICS	0	178,685	178,685	0	178,685	194.00
194.01	07951	PATIENT & FAMILY SUPPORT	0	0	0	170,774	170,774	194.01
194.02	07952	DONOR DEVELOPMENT	405,770	313,004	718,774	0	718,774	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	9,064,001	22,944,404	32,008,405	0	32,008,405	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 26-3304

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

Worksheet A  
Date/Time Prepared:  
5/23/2019 12:47 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	1,892,440	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	890,560	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,512,350	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,675,365	5,893,431	5.00
7.00	00700	OPERATION OF PLANT	0	750,034	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	72,436	8.00
9.00	00900	HOUSEKEEPING	0	284,214	9.00
10.00	01000	DIETARY	-158,044	369,513	10.00
11.00	01100	CAFETERIA	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	460,852	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	118,255	14.00
15.00	01500	PHARMACY	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3,209	155,388	16.00
17.00	01700	SOCIAL SERVICE	0	542,636	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-919,095	781,402	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	34.00
40.00	04000	SUBPROVIDER - I PF	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-2,702,806	1,078,125	50.00
51.00	05100	RECOVERY ROOM	0	583,106	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-1,367,282	163,288	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-266,483	372,617	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-295,428	80,503	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	-660	201,660	65.00
66.00	06600	PHYSICAL THERAPY	-7,217	520,796	66.00
67.00	06700	OCCUPATIONAL THERAPY	-12,113	270,519	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	283,158	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	169,168	3,950,777	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-2,753	427,972	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	-929	333,118	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
94.00	09400	HOME PROGRAM DIALYSIS	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
99.00	09900	CMHC	0	0	99.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 26-3304

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

Worksheet A  
Date/Time Prepared:  
5/23/2019 12:47 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
99.10	09910	CORF	6.00	7.00	
100.00	10000	I & R SERVICES-NOT APPRVD PRGM	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	100.00
SPECIAL PURPOSE COST CENTERS					
105.00	10500	KIDNEY ACQUISITION	0	0	101.00
106.00	10600	HEART ACQUISITION	0	0	105.00
107.00	10700	LIVER ACQUISITION	0	0	106.00
108.00	10800	LUNG ACQUISITION	0	0	107.00
109.00	10900	PANCREAS ACQUISITION	0	0	108.00
110.00	11000	INTESTINAL ACQUISITION	0	0	109.00
111.00	11100	ISLET ACQUISITION	0	0	110.00
113.00	11300	INTEREST EXPENSE	0	0	111.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	114.00
116.00	11600	HOSPICE	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,891,486	23,989,150	116.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	118.00
191.00	19100	RESEARCH	0	5,049,010	190.00
191.01	19101	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	10,526	191.01
193.00	19300	NONPAID WORKERS	0	0	192.00
194.00	07950	ORTHOTICS & PROSTHETICS	0	178,685	193.00
194.01	07951	PATIENT & FAMILY SUPPORT	0	170,774	194.00
194.02	07952	DONOR DEVELOPMENT	0	718,774	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,891,486	30,116,919	194.02

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
<b>A - DEPRECIATION</b>						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	795,170	1.00	
	TOTALS		0	795,170		
<b>B - INSURANCE</b>						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	95,390	1.00	
	TOTALS		0	95,390		
<b>C - MEDICAL SUPPLIES</b>						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	283,158	1.00	
	TOTALS		0	283,158		
<b>D - IMPLANTS &amp; DEVICES</b>						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	3,781,609	1.00	
	TOTALS		0	3,781,609		
<b>E - CHIEF OF STAFF</b>						
1.00	OPERATING ROOM	50.00	0	340,873	1.00	
	TOTALS		0	340,873		
<b>F - PURCHASED MEDICAL SERVICES</b>						
1.00	PATIENT & FAMILY SUPPORT	194.01	0	170,774	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
	TOTALS		0	170,774		
500.00	Grand Total: Increases		0	5,466,974	500.00	

RECLASSIFICATIONS

Provider CCN: 26-3304

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

Worksheet A-6

Date/Time Prepared:  
5/23/2019 12:47 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - DEPRECIATION							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	795,170	9		1.00
	TOTALS		0	795,170			
B - INSURANCE							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	95,390	12		1.00
	TOTALS		0	95,390			
C - MEDICAL SUPPLIES							
1.00	OPERATING ROOM	50.00	0	283,158	0		1.00
	TOTALS		0	283,158			
D - IMPLANTS & DEVICES							
1.00	OPERATING ROOM	50.00	0	3,781,609	0		1.00
	TOTALS		0	3,781,609			
E - CHIEF OF STAFF							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	340,873	0		1.00
	TOTALS		0	340,873			
F - PURCHASED MEDICAL SERVICES							
1.00	OPERATING ROOM	50.00	0	5,992	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	64,356	0		2.00
3.00	LABORATORY	60.00	0	100,426	0		3.00
	TOTALS		0	170,774			
500.00	Grand Total: Decreases		0	5,466,974			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-3304

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
5/23/2019 12:47 pm

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-3304

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
5/23/2019 12:47 pm

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-3304

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
5/23/2019 12:47 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,860,063	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	795,170	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,655,233	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	-95,390	0	0	1,764,673	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	95,390	0	0	890,560	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	2,655,233	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 26-3304

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

Worksheet A-8

Date/Time Prepared:  
5/23/2019 12:47 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-11,301		ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)	B	-1,707		ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-5,198,043				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)	B	-1,089		RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	3,692,555				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-156,824		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	-3,209		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	-1,220		DIETARY	10.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)				UTILIZATION REVIEW-SNF	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)				ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 26-3304

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

Worksheet A-8

Date/Time Prepared:  
5/23/2019 12:47 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
33.00 INVENTORY ADJUSTMENT	A	169,168	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	33.00
33.01 LOBBYING EXPENSE	A	-4,182	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02 RESEARCH COST	A	-87,458	RADIOLOGY-DIAGNOSTIC	54.00	0	33.02
33.03 RESEARCH COST	A	-264,504	LABORATORY	60.00	0	33.03
33.04 RESEARCH COST	A	-660	RESPIRATORY THERAPY	65.00	0	33.04
33.05 RESEARCH COST	A	-7,217	PHYSICAL THERAPY	66.00	0	33.05
33.06 RESEARCH COST	A	-12,113	OCCUPATIONAL THERAPY	67.00	0	33.06
33.07 RESEARCH COST	A	-2,753	DRUGS CHARGED TO PATIENTS	73.00	0	33.07
33.08 RESEARCH COST	A	-929	CLINIC	90.00	0	33.08
33.09 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.09
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,891,486				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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

Provider CCN: 26-3304

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

Worksheet A-8-1

Date/Time Prepared:  
5/23/2019 12:47 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	68000 INSURANCE	202,703	202,703 1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	68000 INSURANCE	95,390	95,390 2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	69000 ALLOCATED BENEFITS	2,612,064	2,612,064 3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	3,692,555	0 4.00
4.01	0.00			0	0 4.01
4.02	0.00			0	0 4.02
5.00	0		0	6,602,712	2,910,157 5.00

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

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

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

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

6.00	B	0.00	SHRI NERS	100.00	6.00
7.00		0.00		0.00	7.00
8.00		0.00		0.00	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 26-3304

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

Worksheet A-8-1

Date/Time Prepared:  
5/23/2019 12:47 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>			
1.00	0	12	1.00
2.00	0	12	2.00
3.00	0	0	3.00
4.00	3,692,555	0	4.00
4.01	0	0	4.01
4.02	0	0	4.02
5.00	3,692,555		5.00

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

Related Organization(s) and/or Home Office	Type of Business
6.00	

**B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:**

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

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

6.00	HOME OFFICE	6.00
7.00		7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 26-3304

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

Worksheet A-8-2

Date/Time Prepared:  
5/23/2019 12:47 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	919,095	919,095	0	0	0	1.00
2.00	50.00	OPERATING ROOM	2,702,806	2,702,806	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	1,367,282	1,367,282	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	177,936	177,936	0	0	0	4.00
5.00	60.00	LABORATORY	30,924	30,924	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			5,198,043	5,198,043	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	919,095		1.00
2.00	50.00	OPERATING ROOM	0	0	0	2,702,806		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	1,367,282		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	177,936		4.00
5.00	60.00	LABORATORY	0	0	0	30,924		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	5,198,043		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-3304

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/23/2019 12:47 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100 CAP REL COSTS-BLDG & FIXT	1,892,440	1,892,440				1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP	890,560		890,560			2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	3,512,350	6,399	3,011	3,521,760		4.00
5.00 00500 ADMINISTRATIVE & GENERAL	5,893,431	973,993	458,350	520,762	7,846,536	5.00
7.00 00700 OPERATION OF PLANT	750,034	226,957	106,803	42,815	1,126,609	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	72,436	6,221	2,928	0	81,585	8.00
9.00 00900 HOUSEKEEPING	284,214	12,020	5,656	90,934	392,824	9.00
10.00 01000 DIETARY	369,513	9,532	4,485	0	383,530	10.00
11.00 01100 CAFETERIA	0	0	0	0	0	11.00
12.00 01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 01300 NURSING ADMINISTRATION	460,852	2,333	1,098	179,713	643,996	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	118,255	29,861	14,052	39,081	201,249	14.00
15.00 01500 PHARMACY	0	0	0	0	0	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	155,388	18,063	8,500	59,922	241,873	16.00
17.00 01700 SOCIAL SERVICE	542,636	10,931	5,144	212,742	771,453	17.00
18.00 01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00 02300 PARAMED PRGM-(SPECIFY)	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	781,402	61,322	28,857	435,996	1,307,577	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00 03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00 04000 SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00 04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300 NURSERY	0	0	0	0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00 04500 NURSING FACILITY	0	0	0	0	0	45.00
46.00 04600 OTHER LONG TERM CARE	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	1,078,125	53,456	25,156	255,112	1,411,849	50.00
51.00 05100 RECOVERY ROOM	583,106	16,486	7,758	214,570	821,920	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	163,288	2,044	962	33,453	199,747	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	372,617	50,879	23,943	159,435	606,874	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	80,503	27,106	12,756	78,816	199,181	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	201,660	4,310	2,028	78,465	286,463	65.00
66.00 06600 PHYSICAL THERAPY	520,796	29,150	13,718	208,837	772,501	66.00
67.00 06700 OCCUPATIONAL THERAPY	270,519	21,040	9,901	109,476	410,936	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	283,158	0	0	0	283,158	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	3,950,777	0	0	0	3,950,777	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	427,972	8,287	3,900	92,370	532,529	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000 CLINIC	333,118	57,167	26,902	121,630	538,817	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-3304

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/23/2019 12:47 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00 09900 CMHC	0	0	0	0	0	99.00
99.10 09910 CORF	0	0	0	0	0	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00 10600 HEART ACQUISITION	0	0	0	0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 11600 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	23,989,150	1,627,557	765,908	2,934,129	23,011,984	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100 RESEARCH	5,049,010	189,186	89,029	421,364	5,748,589	191.00
191.01 19101 RESEARCH	0	0	0	0	0	191.01
192.00 19200 PHYSICIANS' PRIVATE OFFICES	10,526	0	0	4,204	14,730	192.00
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950 ORTHOTICS & PROSTHETICS	178,685	19,930	9,379	0	207,994	194.00
194.01 07951 PATIENT & FAMILY SUPPORT	170,774	42,325	19,918	0	233,017	194.01
194.02 07952 DONOR DEVELOPMENT	718,774	13,442	6,326	162,063	900,605	194.02
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	30,116,919	1,892,440	890,560	3,521,760	30,116,919	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 26-3304		Period: From 01/01/2018 To 12/31/2018		Worksheet B Part I Date/Time Prepared: 5/23/2019 12:47 pm	
Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>								
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	7,846,536					5.00
7.00	00700	OPERATION OF PLANT	396,939	1,523,548				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,745	13,835	124,165			8.00
9.00	00900	HOUSEKEEPING	138,404	26,731	5,963	563,922		9.00
10.00	01000	DIETARY	135,130	21,197	2,188	8,060	550,105	10.00
11.00	01100	CAFETERIA	0	0	0	0	429,080	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	226,900	5,188	0	1,973	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	70,906	66,407	0	25,252	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	85,219	40,170	0	15,275	0	16.00
17.00	01700	SOCIAL SERVICE	271,807	24,310	0	9,244	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	460,700	136,371	24,277	51,857	121,025	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	04000	SUBPROVIDER - I PF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	497,438	118,880	22,314	45,205	0	50.00
51.00	05100	RECOVERY ROOM	289,588	36,662	19,510	13,941	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	70,377	4,546	0	1,729	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	213,821	113,148	4,972	43,026	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	70,178	60,280	0	22,922	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	100,930	9,585	0	3,645	0	65.00
66.00	06600	PHYSICAL THERAPY	272,176	64,826	12,572	24,651	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	144,785	46,791	6,286	17,793	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	99,765	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,391,981	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	187,626	18,430	0	7,008	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	189,842	127,131	6,423	48,343	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-3304

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/23/2019 12:47 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
105.00	10500 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600 HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300 INTEREST EXPENSE						113.00
114.00	11400 UTILIZATION REVIEW-SNF						114.00
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600 HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	5,343,257	934,488	104,505	339,924	550,105	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100 RESEARCH	2,025,396	420,722	0	159,986	0	191.00
191.01	19101 RESEARCH	0	0	0	0	0	191.01
192.00	19200 PHYSICIANS' PRIVATE OFFICES	5,190	0	0	0	0	192.00
193.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950 ORTHOTICS & PROSTHETICS	73,283	44,320	0	16,853	0	194.00
194.01	07951 PATIENT & FAMILY SUPPORT	82,099	94,125	19,660	35,792	0	194.01
194.02	07952 DONOR DEVELOPMENT	317,311	29,893	0	11,367	0	194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	7,846,536	1,523,548	124,165	563,922	550,105	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-3304

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/23/2019 12:47 pm

Cost Center Description		CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		11.00	12.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	429,080					11.00
12.00	01200		0				12.00
13.00	01300	16,145	0	894,202			13.00
14.00	01400	10,457	0	0	374,271		14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	11,463	0	0	0	0	16.00
17.00	01700	31,195	0	0	0	0	17.00
18.00	01850	0	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
23.00	02300	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	54,954	0	263,580	0	0	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
34.00	03400	0	0	0	0	0	34.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	34,433	0	165,158	0	0	50.00
51.00	05100	26,426	0	126,754	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	3,675	0	17,628	0	0	53.00
54.00	05400	23,758	0	0	0	0	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	11,769	0	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	12,426	0	0	0	0	65.00
66.00	06600	27,783	0	0	0	0	66.00
67.00	06700	18,026	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	26,199	0	71.00
72.00	07200	0	0	0	348,072	0	72.00
73.00	07300	8,269	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	23,101	0	110,805	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	0	0	0	0	95.00
96.00	09600	0	0	0	0	0	96.00
97.00	09700	0	0	0	0	0	97.00
98.00	09850	0	0	0	0	0	98.00
99.00	09900	0	0	0	0	0	99.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-3304

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/23/2019 12:47 pm

Cost Center Description			CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	313,880	0	683,925	374,271		118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	43,840	0	210,277	0	0	191.00
191.01	19101	RESEARCH	0	0	0	0	0	191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ORTHOTICS & PROSTHETICS	33,208	0	0	0	0	194.00
194.01	07951	PATIENT & FAMILY SUPPORT	11,463	0	0	0	0	194.01
194.02	07952	DONOR DEVELOPMENT	26,689	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	429,080	0	894,202	374,271		202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-3304

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/23/2019 12:47 pm

Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	NONPHYSICIAN ANESTHETISTS	PARAMED PRGM	
	16.00	17.00	18.00	19.00	23.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
11.00 01100 CAFETERIA						11.00
12.00 01200 MAINTENANCE OF PERSONNEL						12.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY						15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	394,000					16.00
17.00 01700 SOCIAL SERVICE	0	1,108,009				17.00
18.00 01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	0			18.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
23.00 02300 PARAMED PRGM-(SPECIFY)	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	24,534	1,108,009	0	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00 03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00 04000 SUBPROVIDER - I PF	0	0	0	0	0	40.00
41.00 04100 SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300 NURSERY	0	0	0	0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00 04500 NURSING FACILITY	0	0	0	0	0	45.00
46.00 04600 OTHER LONG TERM CARE	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	116,087	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	19,706	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	38,917	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	27,654	0	0	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	2,036	0	0	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	7,708	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	16,863	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	6,090	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16,170	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	78,321	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	23,319	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000 CLINIC	16,595	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-3304

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/23/2019 12:47 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	NONPHYSICIAN ANESTHETISTS	PARAMED ED PRGM		
					16.00				17.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	0	99.10
100.00	10000	I & R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>									
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE							113.00
114.00	11400	UTILIZATION REVIEW-SNF							114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	394,000	1,108,009	0	0	0	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>									
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	0	191.00
191.01	19101	RESEARCH	0	0	0	0	0	0	191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	0	193.00
194.00	07950	ORTHOTICS & PROSTHETICS	0	0	0	0	0	0	194.00
194.01	07951	PATIENT & FAMILY SUPPORT	0	0	0	0	0	0	194.01
194.02	07952	DONOR DEVELOPMENT	0	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments							200.00
201.00		Negative Cost Centers	0	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	394,000	1,108,009	0	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-3304

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/23/2019 12:47 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
12.00	01200				12.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
18.00	01850				18.00
19.00	01900				19.00
23.00	02300				23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	3,552,884	0	3,552,884	30.00
31.00	03100	0	0	0	31.00
32.00	03200	0	0	0	32.00
33.00	03300	0	0	0	33.00
34.00	03400	0	0	0	34.00
40.00	04000	0	0	0	40.00
41.00	04100	0	0	0	41.00
42.00	04200	0	0	0	42.00
43.00	04300	0	0	0	43.00
44.00	04400	0	0	0	44.00
45.00	04500	0	0	0	45.00
46.00	04600	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	2,411,364	0	2,411,364	50.00
51.00	05100	1,354,507	0	1,354,507	51.00
52.00	05200	0	0	0	52.00
53.00	05300	336,619	0	336,619	53.00
54.00	05400	1,033,253	0	1,033,253	54.00
55.00	05500	0	0	0	55.00
56.00	05600	0	0	0	56.00
57.00	05700	0	0	0	57.00
58.00	05800	0	0	0	58.00
59.00	05900	0	0	0	59.00
60.00	06000	366,366	0	366,366	60.00
60.01	06001	0	0	0	60.01
61.00	06100	0	0	0	61.00
62.00	06200	0	0	0	62.00
63.00	06300	0	0	0	63.00
64.00	06400	0	0	0	64.00
65.00	06500	420,757	0	420,757	65.00
66.00	06600	1,191,372	0	1,191,372	66.00
67.00	06700	650,707	0	650,707	67.00
68.00	06800	0	0	0	68.00
69.00	06900	0	0	0	69.00
70.00	07000	0	0	0	70.00
71.00	07100	425,292	0	425,292	71.00
72.00	07200	5,769,151	0	5,769,151	72.00
73.00	07300	777,181	0	777,181	73.00
74.00	07400	0	0	0	74.00
75.00	07500	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	0	0	0	88.00
89.00	08900	0	0	0	89.00
90.00	09000	1,061,057	0	1,061,057	90.00
91.00	09100	0	0	0	91.00
92.00	09200	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
94.00	09400	0	0	0	94.00
95.00	09500	0	0	0	95.00
96.00	09600	0	0	0	96.00
97.00	09700	0	0	0	97.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-3304

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/23/2019 12:47 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	98.00
99.00	09900	CMHC	0	0	0	99.00
99.10	09910	CORF	0	0	0	99.10
100.00	10000	I & R SERVICES-NOT APPRVD PRGM	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
105.00	10500	KIDNEY ACQUISITION	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,350,510	0	19,350,510	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
191.00	19100	RESEARCH	8,608,810	0	8,608,810	191.00
191.01	19101	RESEARCH	0	0	0	191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	19,920	0	19,920	192.00
193.00	19300	NONPAID WORKERS	0	0	0	193.00
194.00	07950	ORTHOTICS & PROSTHETICS	375,658	0	375,658	194.00
194.01	07951	PATIENT & FAMILY SUPPORT	476,156	0	476,156	194.01
194.02	07952	DONOR DEVELOPMENT	1,285,865	0	1,285,865	194.02
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	30,116,919	0	30,116,919	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-3304

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/23/2019 12:47 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
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	6,399	3,011	9,410	9,410 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	973,993	458,350	1,432,343	1,393 5.00
7.00 00700	OPERATION OF PLANT	0	226,957	106,803	333,760	114 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	6,221	2,928	9,149	0 8.00
9.00 00900	HOUSEKEEPING	0	12,020	5,656	17,676	243 9.00
10.00 01000	DIETARY	0	9,532	4,485	14,017	0 10.00
11.00 01100	CAFETERIA	0	0	0	0	0 11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00 01300	NURSING ADMINISTRATION	0	2,333	1,098	3,431	480 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	29,861	14,052	43,913	104 14.00
15.00 01500	PHARMACY	0	0	0	0	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	18,063	8,500	26,563	160 16.00
17.00 01700	SOCIAL SERVICE	0	10,931	5,144	16,075	568 17.00
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0 18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
23.00 02300	PARAMEDICAL PRGM-(SPECIFY)	0	0	0	0	0 23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	61,322	28,857	90,179	1,165 30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00
32.00 03200	CORONARY CARE UNIT	0	0	0	0	0 32.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0 33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0 34.00
40.00 04000	SUBPROVIDER - IPF	0	0	0	0	0 40.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0 41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0 42.00
43.00 04300	NURSERY	0	0	0	0	0 43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
45.00 04500	NURSING FACILITY	0	0	0	0	0 45.00
46.00 04600	OTHER LONG TERM CARE	0	0	0	0	0 46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	53,456	25,156	78,612	682 50.00
51.00 05100	RECOVERY ROOM	0	16,486	7,758	24,244	573 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00 05300	ANESTHESIOLOGY	0	2,044	962	3,006	89 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	50,879	23,943	74,822	426 54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0 55.00
56.00 05600	RADIOISOTOPE	0	0	0	0	0 56.00
57.00 05700	CT SCAN	0	0	0	0	0 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	0	27,106	12,756	39,862	211 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0 61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0 62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0 63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	0	4,310	2,028	6,338	210 65.00
66.00 06600	PHYSICAL THERAPY	0	29,150	13,718	42,868	558 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	21,040	9,901	30,941	292 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	8,287	3,900	12,187	247 73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	0 74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0 75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
90.00 09000	CLINIC	0	57,167	26,902	84,069	325 90.00
91.00 09100	EMERGENCY	0	0	0	0	0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	0 94.00
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0 96.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-3304

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/23/2019 12:47 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00 09900 CMHC	0	0	0	0	0	99.00
99.10 09910 CORF	0	0	0	0	0	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00 10600 HEART ACQUISITION	0	0	0	0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 11600 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	1,627,557	765,908	2,393,465	7,840	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100 RESEARCH	0	189,186	89,029	278,215	1,126	191.00
191.01 19101 RESEARCH	0	0	0	0	0	191.01
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	11	192.00
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950 ORTHOTICS & PROSTHETICS	0	19,930	9,379	29,309	0	194.00
194.01 07951 PATIENT & FAMILY SUPPORT	0	42,325	19,918	62,243	0	194.01
194.02 07952 DONOR DEVELOPMENT	0	13,442	6,326	19,768	433	194.02
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	1,892,440	890,560	2,783,000	9,410	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 26-3304		Period: From 01/01/2018 To 12/31/2018		Worksheet B Part II Date/Time Prepared: 5/23/2019 12:47 pm	
Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,433,736					5.00
7.00	00700	OPERATION OF PLANT	72,530	406,404				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,252	3,690	18,091			8.00
9.00	00900	HOUSEKEEPING	25,290	7,130	869	51,208		9.00
10.00	01000	DIETARY	24,691	5,654	319	732	45,413	10.00
11.00	01100	CAFETERIA	0	0	0	0	35,422	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	41,460	1,384	0	179	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,956	17,714	0	2,293	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,572	10,715	0	1,387	0	16.00
17.00	01700	SOCIAL SERVICE	49,665	6,485	0	839	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	84,180	36,377	3,537	4,709	9,991	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	04000	SUBPROVIDER - I PF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	90,893	31,711	3,251	4,105	0	50.00
51.00	05100	RECOVERY ROOM	52,914	9,780	2,843	1,266	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	12,860	1,213	0	157	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	39,070	30,182	724	3,907	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	12,823	16,080	0	2,081	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	18,442	2,557	0	331	0	65.00
66.00	06600	PHYSICAL THERAPY	49,733	17,292	1,832	2,238	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	26,456	12,481	916	1,616	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,229	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	254,347	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,284	4,916	0	636	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	34,688	33,912	936	4,390	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-3304

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/23/2019 12:47 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	976,335	249,273	15,227	30,866	45,413	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	370,082	112,227	0	14,530	0	191.00
191.01	19101	RESEARCH	0	0	0	0	0	191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	948	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ORTHOTICS & PROSTHETICS	13,390	11,822	0	1,530	0	194.00
194.01	07951	PATIENT & FAMILY SUPPORT	15,001	25,108	2,864	3,250	0	194.01
194.02	07952	DONOR DEVELOPMENT	57,980	7,974	0	1,032	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,433,736	406,404	18,091	51,208	45,413	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-3304

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/23/2019 12:47 pm

Cost Center Description		CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		11.00	12.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	35,422					11.00
12.00	01200	0	0				12.00
13.00	01300	1,333	0	48,267			13.00
14.00	01400	863	0	0	77,843		14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	946	0	0	0	0	16.00
17.00	01700	2,575	0	0	0	0	17.00
18.00	01850	0	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
23.00	02300	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	4,537	0	14,227	0	0	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
34.00	03400	0	0	0	0	0	34.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	2,843	0	8,915	0	0	50.00
51.00	05100	2,182	0	6,842	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	303	0	952	0	0	53.00
54.00	05400	1,961	0	0	0	0	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	972	0	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	1,026	0	0	0	0	65.00
66.00	06600	2,294	0	0	0	0	66.00
67.00	06700	1,488	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	5,449	0	71.00
72.00	07200	0	0	0	72,394	0	72.00
73.00	07300	683	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	1,907	0	5,981	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	0	0	0	0	95.00
96.00	09600	0	0	0	0	0	96.00
97.00	09700	0	0	0	0	0	97.00
98.00	09850	0	0	0	0	0	98.00
99.00	09900	0	0	0	0	0	99.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-3304

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/23/2019 12:47 pm

Cost Center Description			CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,913	0	36,917	77,843		118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	3,619	0	11,350	0	0	191.00
191.01	19101	RESEARCH	0	0	0	0	0	191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ORTHOTICS & PROSTHETICS	2,741	0	0	0	0	194.00
194.01	07951	PATIENT & FAMILY SUPPORT	946	0	0	0	0	194.01
194.02	07952	DONOR DEVELOPMENT	2,203	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	35,422	0	48,267	77,843		202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 26-3304	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Prepared: 5/23/2019 12:47 pm
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Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	NONPHYSICIAN ANESTHETISTS	PARAMED PRGM	
	16.00	17.00	18.00	19.00	23.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
12.00 01200	MAINTENANCE OF PERSONNEL					12.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	55,343				16.00
17.00 01700	SOCIAL SERVICE	0	76,207			17.00
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0		18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
23.00 02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	3,446	76,207	0		30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0		31.00
32.00 03200	CORONARY CARE UNIT	0	0	0		32.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0		33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0		34.00
40.00 04000	SUBPROVIDER - I PF	0	0	0		40.00
41.00 04100	SUBPROVIDER - I RF	0	0	0		41.00
42.00 04200	SUBPROVIDER	0	0	0		42.00
43.00 04300	NURSERY	0	0	0		43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0		44.00
45.00 04500	NURSING FACILITY	0	0	0		45.00
46.00 04600	OTHER LONG TERM CARE	0	0	0		46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	16,308	0	0		50.00
51.00 05100	RECOVERY ROOM	2,768	0	0		51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00 05300	ANESTHESIOLOGY	5,466	0	0		53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,884	0	0		54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
56.00 05600	RADIOISOTOPE	0	0	0		56.00
57.00 05700	CT SCAN	0	0	0		57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00 06000	LABORATORY	286	0	0		60.00
60.01 06001	BLOOD LABORATORY	0	0	0		60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0		61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00 06500	RESPIRATORY THERAPY	1,083	0	0		65.00
66.00 06600	PHYSICAL THERAPY	2,369	0	0		66.00
67.00 06700	OCCUPATIONAL THERAPY	855	0	0		67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,271	0	0		71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	11,001	0	0		72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	3,275	0	0		73.00
74.00 07400	RENAL DIALYSIS	0	0	0		74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00 09000	CLINIC	2,331	0	0		90.00
91.00 09100	EMERGENCY	0	0	0		91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0		94.00
95.00 09500	AMBULANCE SERVICES	0	0	0		95.00
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
97.00 09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0		97.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-3304

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/23/2019 12:47 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	NONPHYSICIAN ANESTHETISTS	PARAMEDICAL PRGM	
					16.00			
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0		98.00
99.00	09900	CMHC	0	0	0	0		99.00
99.10	09910	CORF	0	0	0	0		99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0		105.00
106.00	10600	HEART ACQUISITION	0	0	0	0		106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0		107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0		108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0		111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0		113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0		114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0		115.00
116.00	11600	HOSPICE	0	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	55,343	76,207	0	0	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0	0		191.00
191.01	19101	RESEARCH	0	0	0	0		191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	ORTHOTICS & PROSTHETICS	0	0	0	0		194.00
194.01	07951	PATIENT & FAMILY SUPPORT	0	0	0	0		194.01
194.02	07952	DONOR DEVELOPMENT	0	0	0	0		194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	55,343	76,207	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 26-3304	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Prepared: 5/23/2019 12:47 pm
Cost Center	Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
12.00	01200				12.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
18.00	01850				18.00
19.00	01900				19.00
23.00	02300				23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	328,555	0	328,555	30.00
31.00	03100	0	0	0	31.00
32.00	03200	0	0	0	32.00
33.00	03300	0	0	0	33.00
34.00	03400	0	0	0	34.00
40.00	04000	0	0	0	40.00
41.00	04100	0	0	0	41.00
42.00	04200	0	0	0	42.00
43.00	04300	0	0	0	43.00
44.00	04400	0	0	0	44.00
45.00	04500	0	0	0	45.00
46.00	04600	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	237,320	0	237,320	50.00
51.00	05100	103,412	0	103,412	51.00
52.00	05200	0	0	0	52.00
53.00	05300	24,046	0	24,046	53.00
54.00	05400	154,976	0	154,976	54.00
55.00	05500	0	0	0	55.00
56.00	05600	0	0	0	56.00
57.00	05700	0	0	0	57.00
58.00	05800	0	0	0	58.00
59.00	05900	0	0	0	59.00
60.00	06000	72,315	0	72,315	60.00
60.01	06001	0	0	0	60.01
61.00	06100	0	0	0	61.00
62.00	06200	0	0	0	62.00
63.00	06300	0	0	0	63.00
64.00	06400	0	0	0	64.00
65.00	06500	29,987	0	29,987	65.00
66.00	06600	119,184	0	119,184	66.00
67.00	06700	75,045	0	75,045	67.00
68.00	06800	0	0	0	68.00
69.00	06900	0	0	0	69.00
70.00	07000	0	0	0	70.00
71.00	07100	25,949	0	25,949	71.00
72.00	07200	337,742	0	337,742	72.00
73.00	07300	56,228	0	56,228	73.00
74.00	07400	0	0	0	74.00
75.00	07500	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	0	0	0	88.00
89.00	08900	0	0	0	89.00
90.00	09000	168,539	0	168,539	90.00
91.00	09100	0	0	0	91.00
92.00	09200	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
94.00	09400	0	0	0	94.00
95.00	09500	0	0	0	95.00
96.00	09600	0	0	0	96.00
97.00	09700	0	0	0	97.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-3304

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/23/2019 12:47 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	98.00
99.00	09900	CMHC	0	0	0	99.00
99.10	09910	CORF	0	0	0	99.10
100.00	10000	I & R SERVICES-NOT APPRVD PRGM	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
105.00	10500	KIDNEY ACQUISITION	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,733,298	0	1,733,298	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
191.00	19100	RESEARCH	791,149	0	791,149	191.00
191.01	19101	RESEARCH	0	0	0	191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	959	0	959	192.00
193.00	19300	NONPAID WORKERS	0	0	0	193.00
194.00	07950	ORTHOTICS & PROSTHETICS	58,792	0	58,792	194.00
194.01	07951	PATIENT & FAMILY SUPPORT	109,412	0	109,412	194.01
194.02	07952	DONOR DEVELOPMENT	89,390	0	89,390	194.02
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,783,000	0	2,783,000	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-3304

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

Worksheet B-1

Date/Time Prepared:  
5/23/2019 12:47 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	85,176				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		85,176			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	288	288	8,817,707		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	43,838	43,838	1,303,865	-7,846,536	5.00
7.00 00700	OPERATION OF PLANT	10,215	10,215	107,199	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	280	280	0	0	8.00
9.00 00900	HOUSEKEEPING	541	541	227,680	0	9.00
10.00 01000	DIETARY	429	429	0	0	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	105	105	449,963	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,344	1,344	97,851	0	14.00
15.00 01500	PHARMACY	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	813	813	150,032	0	16.00
17.00 01700	SOCIAL SERVICE	492	492	532,659	0	17.00
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
23.00 02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	2,760	2,760	1,091,639	0	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
32.00 03200	CORONARY CARE UNIT	0	0	0	0	32.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
40.00 04000	SUBPROVIDER - I PF	0	0	0	0	40.00
41.00 04100	SUBPROVIDER - I RF	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	0	0	0	0	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00 04500	NURSING FACILITY	0	0	0	0	45.00
46.00 04600	OTHER LONG TERM CARE	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	2,406	2,406	638,745	0	50.00
51.00 05100	RECOVERY ROOM	742	742	537,236	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	92	92	83,758	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,290	2,290	399,190	0	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00 05600	RADIOISOTOPE	0	0	0	0	56.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	1,220	1,220	197,338	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	194	194	196,458	0	65.00
66.00 06600	PHYSICAL THERAPY	1,312	1,312	522,882	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	947	947	274,103	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	373	373	231,275	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	2,573	2,573	304,535	0	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-3304

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

Worksheet B-1

Date/Time Prepared:  
5/23/2019 12:47 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	73,254	73,254	7,346,408	-7,846,536	15,165,448	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	8,515	8,515	1,055,003	0	5,748,589	191.00
191.01	19101	RESEARCH	0	0	0	0	0	191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	10,526	0	14,730	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ORTHOTICS & PROSTHETICS	897	897	0	0	207,994	194.00
194.01	07951	PATIENT & FAMILY SUPPORT	1,905	1,905	0	0	233,017	194.01
194.02	07952	DONOR DEVELOPMENT	605	605	405,770	0	900,605	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,892,440	890,560	3,521,760		7,846,536	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	22.217996	10.455527	0.399396		0.352331	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			9,410		1,433,736	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001067		0.064379	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-3304

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

Worksheet B-1

Date/Time Prepared:  
5/23/2019 12:47 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700	30,835					7.00
8.00	00800	280	70,419				8.00
9.00	00900	541	3,382	30,014			9.00
10.00	01000	429	1,241	429	17,327		10.00
11.00	01100	0	0	0	13,515	9,807	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	105	0	105	0	369	13.00
14.00	01400	1,344	0	1,344	0	239	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	813	0	813	0	262	16.00
17.00	01700	492	0	492	0	713	17.00
18.00	01850	0	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
23.00	02300	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	2,760	13,768	2,760	3,812	1,256	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
34.00	03400	0	0	0	0	0	34.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	2,406	12,655	2,406	0	787	50.00
51.00	05100	742	11,065	742	0	604	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	92	0	92	0	84	53.00
54.00	05400	2,290	2,820	2,290	0	543	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	1,220	0	1,220	0	269	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	194	0	194	0	284	65.00
66.00	06600	1,312	7,130	1,312	0	635	66.00
67.00	06700	947	3,565	947	0	412	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	373	0	373	0	189	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	2,573	3,643	2,573	0	528	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	0	0	0	0	95.00
96.00	09600	0	0	0	0	0	96.00
97.00	09700	0	0	0	0	0	97.00
98.00	09850	0	0	0	0	0	98.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-3304

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

Worksheet B-1

Date/Time Prepared:  
5/23/2019 12:47 pm

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,913	59,269	18,092	17,327	7,174	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	8,515	0	8,515	0	1,002	191.00
191.01	19101	RESEARCH	0	0	0	0	0	191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ORTHOTICS & PROSTHETICS	897	0	897	0	759	194.00
194.01	07951	PATIENT & FAMILY SUPPORT	1,905	11,150	1,905	0	262	194.01
194.02	07952	DONOR DEVELOPMENT	605	0	605	0	610	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,523,548	124,165	563,922	550,105	429,080	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	49.409697	1.763232	18.788632	31.748427	43.752422	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	406,404	18,091	51,208	45,413	35,422	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	13.179958	0.256905	1.706137	2.620938	3.611910	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-3304

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

Worksheet B-1

Date/Time Prepared:  
5/23/2019 12:47 pm

Cost Center Description		MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (NURSING FTES)	CENTRAL SERVICES & SUPPLY (ASSIGNED TIME)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		12.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
12.00	01200	0					12.00
13.00	01300	0	4,261				13.00
14.00	01400	0	0	100			14.00
15.00	01500	0	0	0	100		15.00
16.00	01600	0	0	0	0	37,494,019	16.00
17.00	01700	0	0	0	0	0	17.00
18.00	01850	0	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
23.00	02300	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	0	1,256	0	0	2,334,759	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
34.00	03400	0	0	0	0	0	34.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	787	0	0	11,046,318	50.00
51.00	05100	0	604	0	0	1,875,289	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	84	0	0	3,703,571	53.00
54.00	05400	0	0	0	0	2,631,722	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	0	193,741	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	0	0	0	733,504	65.00
66.00	06600	0	0	0	0	1,604,807	66.00
67.00	06700	0	0	0	0	579,564	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	7	0	1,538,837	71.00
72.00	07200	0	0	93	0	7,453,464	72.00
73.00	07300	0	0	0	100	2,219,124	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	528	0	0	1,579,319	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	0	0	0	0	95.00
96.00	09600	0	0	0	0	0	96.00
97.00	09700	0	0	0	0	0	97.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-3304

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

Worksheet B-1

Date/Time Prepared:  
5/23/2019 12:47 pm

Cost Center Description			MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (NURSING FTES)	CENTRAL SERVICES & SUPPLY (ASSIGNED TIME)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			12.00	13.00	14.00	15.00	16.00	
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,259	100	100	37,494,019	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	1,002	0	0	0	191.00
191.01	19101	RESEARCH	0	0	0	0	0	191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ORTHOTICS & PROSTHETICS	0	0	0	0	0	194.00
194.01	07951	PATIENT & FAMILY SUPPORT	0	0	0	0	0	194.01
194.02	07952	DONOR DEVELOPMENT	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	894,202	374,271	0	394,000	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	209.857310	3,742.710000	0.000000	0.010508	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	48,267	77,843	0	55,343	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	11.327623	778.430000	0.000000	0.001476	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-3304

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

Worksheet B-1

Date/Time Prepared:  
5/23/2019 12:47 pm

Cost Center Description	SOCIAL SERVICE (TOTAL PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY (TIME SPENT))	NONPHYSICIAN ANESTHETISTS (FTES)	PARAMED PRGM (ASSIGNED TIME)			
		18.00				19.00	23.00
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100 CAP REL COSTS-BLDG & FIXT					1.00		
2.00 00200 CAP REL COSTS-MVBLE EQUIP					2.00		
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00		
5.00 00500 ADMINISTRATIVE & GENERAL					5.00		
7.00 00700 OPERATION OF PLANT					7.00		
8.00 00800 LAUNDRY & LINEN SERVICE					8.00		
9.00 00900 HOUSEKEEPING					9.00		
10.00 01000 DIETARY					10.00		
11.00 01100 CAFETERIA					11.00		
12.00 01200 MAINTENANCE OF PERSONNEL					12.00		
13.00 01300 NURSING ADMINISTRATION					13.00		
14.00 01400 CENTRAL SERVICES & SUPPLY					14.00		
15.00 01500 PHARMACY					15.00		
16.00 01600 MEDICAL RECORDS & LIBRARY					16.00		
17.00 01700 SOCIAL SERVICE	1,107				17.00		
18.00 01850 OTHER GENERAL SERVICE (SPECIFY)	0	0			18.00		
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	8,224		19.00		
23.00 02300 PARAMED PRGM-(SPECIFY)	0	0		0	23.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000 ADULTS & PEDIATRICS	1,107	0	1,256	0	30.00		
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0	31.00		
32.00 03200 CORONARY CARE UNIT	0	0	0	0	32.00		
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	33.00		
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00		
40.00 04000 SUBPROVIDER - I/PF	0	0	0	0	40.00		
41.00 04100 SUBPROVIDER - I/RF	0	0	0	0	41.00		
42.00 04200 SUBPROVIDER	0	0	0	0	42.00		
43.00 04300 NURSERY	0	0	0	0	43.00		
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	44.00		
45.00 04500 NURSING FACILITY	0	0	0	0	45.00		
46.00 04600 OTHER LONG TERM CARE	0	0	0	0	46.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	0	0	787	0	50.00		
51.00 05100 RECOVERY ROOM	0	0	604	0	51.00		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00		
53.00 05300 ANESTHESIOLOGY	0	0	84	0	53.00		
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	543	0	54.00		
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00		
56.00 05600 RADIOISOTOPE	0	0	0	0	56.00		
57.00 05700 CT SCAN	0	0	0	0	57.00		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00		
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	59.00		
60.00 06000 LABORATORY	0	0	269	0	60.00		
60.01 06001 BLOOD LABORATORY	0	0	0	0	60.01		
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00		
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00		
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00		
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	64.00		
65.00 06500 RESPIRATORY THERAPY	0	0	284	0	65.00		
66.00 06600 PHYSICAL THERAPY	0	0	635	0	66.00		
67.00 06700 OCCUPATIONAL THERAPY	0	0	412	0	67.00		
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	68.00		
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	69.00		
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	189	0	73.00		
74.00 07400 RENAL DIALYSIS	0	0	0	0	74.00		
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	75.00		
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	88.00		
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00		
90.00 09000 CLINIC	0	0	528	0	90.00		
91.00 09100 EMERGENCY	0	0	0	0	91.00		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00		
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	94.00		
95.00 09500 AMBULANCE SERVICES	0	0	0	0	95.00		
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00		

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-3304

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

Worksheet B-1

Date/Time Prepared:  
5/23/2019 12:47 pm

Cost Center Description		SOCIAL SERVICE (TOTAL PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY) (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (FTES)	PARAMED ED PRGM (ASSIGNED TIME)	
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
99.00	09900 CMHC	0	0	0	0	99.00
99.10	09910 CORF	0	0	0	0	99.10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	100.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00	10500 KIDNEY ACQUISITION	0	0	0	0	105.00
106.00	10600 HEART ACQUISITION	0	0	0	0	106.00
107.00	10700 LIVER ACQUISITION	0	0	0	0	107.00
108.00	10800 LUNG ACQUISITION	0	0	0	0	108.00
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	0	0	111.00
113.00	11300 INTEREST EXPENSE	0	0	0	0	113.00
114.00	11400 UTILIZATION REVIEW-SNF	0	0	0	0	114.00
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	115.00
116.00	11600 HOSPICE	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,107	0	5,591	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100 RESEARCH	0	0	1,002	0	191.00
191.01	19101 RESEARCH	0	0	0	0	191.01
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	19300 NONPAID WORKERS	0	0	0	0	193.00
194.00	07950 ORTHOTICS & PROSTHETICS	0	0	759	0	194.00
194.01	07951 PATIENT & FAMILY SUPPORT	0	0	262	0	194.01
194.02	07952 DONOR DEVELOPMENT	0	0	610	0	194.02
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,108,009	0	0	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1,000.911472	0.000000	0.000000	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	76,207	0	0	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	68.841012	0.000000	0.000000	0.000000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)				0	206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-3304

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/23/2019 12:47 pm

		Title XVIII		Hospital		TEFRA	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS		3,552,884		0	0	30.00
31.00	03100 INTENSIVE CARE UNIT		0		0	0	31.00
32.00	03200 CORONARY CARE UNIT		0		0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT		0		0	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT		0		0	0	34.00
40.00	04000 SUBPROVIDER - I PF		0		0	0	40.00
41.00	04100 SUBPROVIDER - I RF		0		0	0	41.00
42.00	04200 SUBPROVIDER		0		0	0	42.00
43.00	04300 NURSERY		0		0	0	43.00
44.00	04400 SKILLED NURSING FACILITY		0		0	0	44.00
45.00	04500 NURSING FACILITY		0		0	0	45.00
46.00	04600 OTHER LONG TERM CARE		0		0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM		2,411,364		0	0	50.00
51.00	05100 RECOVERY ROOM		1,354,507		0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0		0	0	52.00
53.00	05300 ANESTHESIOLOGY		336,619		0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		1,033,253		0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC		0		0	0	55.00
56.00	05600 RADIOISOTOPE		0		0	0	56.00
57.00	05700 CT SCAN		0		0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0		0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION		0		0	0	59.00
60.00	06000 LABORATORY		366,366		0	0	60.00
60.01	06001 BLOOD LABORATORY		0		0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0		0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0		0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		0		0	0	63.00
64.00	06400 INTRAVENOUS THERAPY		0		0	0	64.00
65.00	06500 RESPIRATORY THERAPY		420,757	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY		1,191,372	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY		650,707	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY		0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY		0		0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		0		0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		425,292		0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		5,769,151		0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		777,181		0	0	73.00
74.00	07400 RENAL DIALYSIS		0		0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)		0		0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC		0		0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0		0	0	89.00
90.00	09000 CLINIC		1,061,057		0	0	90.00
91.00	09100 EMERGENCY		0		0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		6,407		0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400 HOME PROGRAM DIALYSIS		0		0	0	94.00
95.00	09500 AMBULANCE SERVICES		0		0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED		0		0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD		0		0	0	97.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS		0		0	0	98.00
99.00	09900 CMHC		0		0	0	99.00
99.10	09910 CORF		0		0	0	99.10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM		0		0	0	100.00
101.00	10100 HOME HEALTH AGENCY		0		0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
105.00	10500 KIDNEY ACQUISITION		0		0	0	105.00
106.00	10600 HEART ACQUISITION		0		0	0	106.00
107.00	10700 LIVER ACQUISITION		0		0	0	107.00
108.00	10800 LUNG ACQUISITION		0		0	0	108.00
109.00	10900 PANCREAS ACQUISITION		0		0	0	109.00
110.00	11000 INTESTINAL ACQUISITION		0		0	0	110.00
111.00	11100 ISLET ACQUISITION		0		0	0	111.00
113.00	11300 INTEREST EXPENSE						113.00
114.00	11400 UTILIZATION REVIEW-SNF						114.00
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)		0		0	0	115.00
116.00	11600 HOSPICE		0		0	0	116.00
200.00	Subtotal (see instructions)		19,356,917	0	0	0	200.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 26-3304		Period: From 01/01/2018 To 12/31/2018		Worksheet C Part I Date/Time Prepared: 5/23/2019 12:47 pm	
		Title XVIII		Hospital		TEFRA	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
201.00	Less Observation Beds	6,407		6,407			0 201.00
202.00	Total (see instructions)	19,350,510	0	19,350,510	0		0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 26-3304		Period: From 01/01/2018 To 12/31/2018		Worksheet C Part I Date/Time Prepared: 5/23/2019 12:47 pm		
			Title XVIII			Hospital		TEFRA	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>									
30.00	03000	ADULTS & PEDIATRICS	2,330,994		2,330,994			30.00	
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00	
32.00	03200	CORONARY CARE UNIT	0		0			32.00	
33.00	03300	BURN INTENSIVE CARE UNIT	0		0			33.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0			34.00	
40.00	04000	SUBPROVIDER - I PF	0		0			40.00	
41.00	04100	SUBPROVIDER - I RF	0		0			41.00	
42.00	04200	SUBPROVIDER	0		0			42.00	
43.00	04300	NURSERY	0		0			43.00	
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00	
45.00	04500	NURSING FACILITY	0		0			45.00	
46.00	04600	OTHER LONG TERM CARE	0		0			46.00	
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	4,678,624	6,367,694	11,046,318	0.218296	0.218296	50.00	
51.00	05100	RECOVERY ROOM	598,336	1,276,953	1,875,289	0.722292	0.722292	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	1,430,682	2,272,889	3,703,571	0.090890	0.090890	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	299,180	2,332,542	2,631,722	0.392615	0.392615	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00	
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00	
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00	
60.00	06000	LABORATORY	104,964	88,777	193,741	1.891009	1.891009	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01	
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	0.000000	61.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	0.000000	62.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000	63.00	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00	
65.00	06500	RESPIRATORY THERAPY	585,370	148,134	733,504	0.573626	0.573626	65.00	
66.00	06600	PHYSICAL THERAPY	291,960	1,312,847	1,604,807	0.742377	0.742377	66.00	
67.00	06700	OCCUPATIONAL THERAPY	75,541	504,023	579,564	1.122753	1.122753	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,419,864	118,973	1,538,837	0.276372	0.276372	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,972,216	481,248	7,453,464	0.774023	0.774023	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	1,462,430	756,694	2,219,124	0.350220	0.350220	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00	
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>									
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00	
90.00	09000	CLINIC	1,676	1,577,643	1,579,319	0.671845	0.671845	90.00	
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,765	3,765	1.701726	1.701726	92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>									
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	0.000000	94.00	
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00	
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00	
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	0.000000	97.00	
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00	
99.00	09900	CMHC	0	0	0			99.00	
99.10	09910	CORF	0	0	0			99.10	
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0			100.00	
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00	
<b>SPECIAL PURPOSE COST CENTERS</b>									
105.00	10500	KIDNEY ACQUISITION	0	0	0			105.00	
106.00	10600	HEART ACQUISITION	0	0	0			106.00	
107.00	10700	LIVER ACQUISITION	0	0	0			107.00	
108.00	10800	LUNG ACQUISITION	0	0	0			108.00	
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00	
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00	
111.00	11100	ISLET ACQUISITION	0	0	0			111.00	
113.00	11300	INTEREST EXPENSE	0	0	0			113.00	
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0			114.00	
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0			115.00	
116.00	11600	HOSPICE	0	0	0			116.00	
200.00		Subtotal (see instructions)	20,251,837	17,242,182	37,494,019			200.00	
201.00		Less Observation Beds						201.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 26-3304		Period: From 01/01/2018 To 12/31/2018		Worksheet C Part I Date/Time Prepared: 5/23/2019 12:47 pm	
			Title XVIII		Hospital		TEFRA	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
6.00	7.00	8.00	9.00	10.00				
202.00	Total (see instructions)	20,251,837	17,242,182	37,494,019				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 26-3304	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/23/2019 12:47 pm
Cost Center Description			PPS Inpatient Ratio 11.00	Title XVIII	Hospital TEFRA
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
32.00	03200	CORONARY CARE UNIT			32.00
33.00	03300	BURN INTENSIVE CARE UNIT			33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT			34.00
40.00	04000	SUBPROVIDER - I PF			40.00
41.00	04100	SUBPROVIDER - I RF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
46.00	04600	OTHER LONG TERM CARE			46.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000		61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		94.00
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000		97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
99.00	09900	CMHC			99.00
99.10	09910	CORF			99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM			100.00
101.00	10100	HOME HEALTH AGENCY			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
105.00	10500	KIDNEY ACQUISITION			105.00
106.00	10600	HEART ACQUISITION			106.00
107.00	10700	LIVER ACQUISITION			107.00
108.00	10800	LUNG ACQUISITION			108.00
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)			115.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-3304

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/23/2019 12:47 pm

		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS		3,552,884		0	3,552,884	30.00
31.00	03100 INTENSIVE CARE UNIT		0		0	0	31.00
32.00	03200 CORONARY CARE UNIT		0		0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT		0		0	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT		0		0	0	34.00
40.00	04000 SUBPROVIDER - I PF		0		0	0	40.00
41.00	04100 SUBPROVIDER - I RF		0		0	0	41.00
42.00	04200 SUBPROVIDER		0		0	0	42.00
43.00	04300 NURSERY		0		0	0	43.00
44.00	04400 SKILLED NURSING FACILITY		0		0	0	44.00
45.00	04500 NURSING FACILITY		0		0	0	45.00
46.00	04600 OTHER LONG TERM CARE		0		0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM		2,411,364		0	2,411,364	50.00
51.00	05100 RECOVERY ROOM		1,354,507		0	1,354,507	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0		0	0	52.00
53.00	05300 ANESTHESIOLOGY		336,619		0	336,619	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		1,033,253		0	1,033,253	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC		0		0	0	55.00
56.00	05600 RADIOISOTOPE		0		0	0	56.00
57.00	05700 CT SCAN		0		0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0		0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION		0		0	0	59.00
60.00	06000 LABORATORY		366,366		0	366,366	60.00
60.01	06001 BLOOD LABORATORY		0		0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0		0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0		0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		0		0	0	63.00
64.00	06400 INTRAVENOUS THERAPY		0		0	0	64.00
65.00	06500 RESPIRATORY THERAPY		420,757	0	0	420,757	65.00
66.00	06600 PHYSICAL THERAPY		1,191,372	0	0	1,191,372	66.00
67.00	06700 OCCUPATIONAL THERAPY		650,707	0	0	650,707	67.00
68.00	06800 SPEECH PATHOLOGY		0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY		0		0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		0		0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		425,292		0	425,292	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		5,769,151		0	5,769,151	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		777,181		0	777,181	73.00
74.00	07400 RENAL DIALYSIS		0		0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)		0		0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC		0		0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0		0	0	89.00
90.00	09000 CLINIC		1,061,057		0	1,061,057	90.00
91.00	09100 EMERGENCY		0		0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		6,407		0	6,407	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400 HOME PROGRAM DIALYSIS		0		0	0	94.00
95.00	09500 AMBULANCE SERVICES		0		0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED		0		0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD		0		0	0	97.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS		0		0	0	98.00
99.00	09900 CMHC		0		0	0	99.00
99.10	09910 CORF		0		0	0	99.10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM		0		0	0	100.00
101.00	10100 HOME HEALTH AGENCY		0		0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
105.00	10500 KIDNEY ACQUISITION		0		0	0	105.00
106.00	10600 HEART ACQUISITION		0		0	0	106.00
107.00	10700 LIVER ACQUISITION		0		0	0	107.00
108.00	10800 LUNG ACQUISITION		0		0	0	108.00
109.00	10900 PANCREAS ACQUISITION		0		0	0	109.00
110.00	11000 INTESTINAL ACQUISITION		0		0	0	110.00
111.00	11100 ISLET ACQUISITION		0		0	0	111.00
113.00	11300 INTEREST EXPENSE		0		0	0	113.00
114.00	11400 UTILIZATION REVIEW-SNF		0		0	0	114.00
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)		0		0	0	115.00
116.00	11600 HOSPICE		0		0	0	116.00
200.00	Subtotal (see instructions)		19,356,917	0	0	19,356,917	200.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-3304

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/23/2019 12:47 pm

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	
201.00	Less Observation Beds	6,407		6,407		6,407	201.00
202.00	Total (see instructions)	19,350,510	0	19,350,510	0	19,350,510	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-3304

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/23/2019 12:47 pm

			Title XIX			Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>									
30.00	03000	ADULTS & PEDIATRICS	2,330,994		2,330,994				30.00
31.00	03100	INTENSIVE CARE UNIT	0		0				31.00
32.00	03200	CORONARY CARE UNIT	0		0				32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0				33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0				34.00
40.00	04000	SUBPROVIDER - I PF	0		0				40.00
41.00	04100	SUBPROVIDER - I RF	0		0				41.00
42.00	04200	SUBPROVIDER	0		0				42.00
43.00	04300	NURSERY	0		0				43.00
44.00	04400	SKILLED NURSING FACILITY	0		0				44.00
45.00	04500	NURSING FACILITY	0		0				45.00
46.00	04600	OTHER LONG TERM CARE	0		0				46.00
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	4,678,624	6,367,694	11,046,318	0.218296	0.000000		50.00
51.00	05100	RECOVERY ROOM	598,336	1,276,953	1,875,289	0.722292	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	1,430,682	2,272,889	3,703,571	0.090890	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	299,180	2,332,542	2,631,722	0.392615	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000		55.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000		56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000		59.00
60.00	06000	LABORATORY	104,964	88,777	193,741	1.891009	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000		60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	0.000000		61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	0.000000		62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	585,370	148,134	733,504	0.573626	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	291,960	1,312,847	1,604,807	0.742377	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	75,541	504,023	579,564	1.122753	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,419,864	118,973	1,538,837	0.276372	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,972,216	481,248	7,453,464	0.774023	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,462,430	756,694	2,219,124	0.350220	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000		75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000		89.00
90.00	09000	CLINIC	1,676	1,577,643	1,579,319	0.671845	0.000000		90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,765	3,765	1.701726	0.000000		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>									
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	0.000000		94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	0.000000		97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000		98.00
99.00	09900	CMHC	0	0	0	0.000000	0.000000		99.00
99.10	09910	CORF	0	0	0	0.000000	0.000000		99.10
100.00	10000	I & R SERVICES-NOT APPRVD PRGM	0	0	0	0.000000	0.000000		100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0.000000	0.000000		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>									
105.00	10500	KIDNEY ACQUISITION	0	0	0				105.00
106.00	10600	HEART ACQUISITION	0	0	0				106.00
107.00	10700	LIVER ACQUISITION	0	0	0				107.00
108.00	10800	LUNG ACQUISITION	0	0	0				108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0				109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0				110.00
111.00	11100	ISLET ACQUISITION	0	0	0				111.00
113.00	11300	INTEREST EXPENSE	0	0	0				113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0				114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0				115.00
116.00	11600	HOSPICE	0	0	0				116.00
200.00		Subtotal (see instructions)	20,251,837	17,242,182	37,494,019				200.00
201.00		Less Observation Beds							201.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 26-3304		Period: From 01/01/2018 To 12/31/2018		Worksheet C Part I Date/Time Prepared: 5/23/2019 12:47 pm	
			Title XIX		Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col . 6 + col . 7)			
6.00	7.00	8.00	9.00	10.00				
202.00	Total (see instructions)	20,251,837	17,242,182	37,494,019			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 26-3304	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/23/2019 12:47 pm	
Cost Center Description			PPS Inpatient Ratio 11.00	Title XIX	Hospital	Cost
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
32.00	03200	CORONARY CARE UNIT				32.00
33.00	03300	BURN INTENSIVE CARE UNIT				33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT				34.00
40.00	04000	SUBPROVIDER - I PF				40.00
41.00	04100	SUBPROVIDER - I RF				41.00
42.00	04200	SUBPROVIDER				42.00
43.00	04300	NURSERY				43.00
44.00	04400	SKILLED NURSING FACILITY				44.00
45.00	04500	NURSING FACILITY				45.00
46.00	04600	OTHER LONG TERM CARE				46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
60.01	06001	BLOOD LABORATORY	0.000000			60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000			61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000			75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00	09400	HOME PROGRAM DIALYSIS	0.000000			94.00
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000			96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000			97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000			98.00
99.00	09900	CMHC				99.00
99.10	09910	CORF				99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM				100.00
101.00	10100	HOME HEALTH AGENCY				101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
105.00	10500	KIDNEY ACQUISITION				105.00
106.00	10600	HEART ACQUISITION				106.00
107.00	10700	LIVER ACQUISITION				107.00
108.00	10800	LUNG ACQUISITION				108.00
109.00	10900	PANCREAS ACQUISITION				109.00
110.00	11000	INTESTINAL ACQUISITION				110.00
111.00	11100	ISLET ACQUISITION				111.00
113.00	11300	INTEREST EXPENSE				113.00
114.00	11400	UTILIZATION REVIEW-SNF				114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)				115.00
116.00	11600	HOSPICE				116.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 26-3304	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part I Date/Time Prepared: 5/23/2019 12:47 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	328,555	0	328,555	1,109	296.26	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
32.00	CORONARY CARE UNIT	0		0	0	0.00	32.00
33.00	BURN INTENSIVE CARE UNIT	0		0	0	0.00	33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0		0	0	0.00	34.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	0		0	0	0.00	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (lines 30 through 199)	328,555		328,555	1,109		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	0				
31.00	INTENSIVE CARE UNIT	0	0				
32.00	CORONARY CARE UNIT	0	0				
33.00	BURN INTENSIVE CARE UNIT	0	0				
34.00	SURGICAL INTENSIVE CARE UNIT	0	0				
40.00	SUBPROVIDER - IPF	0	0				
41.00	SUBPROVIDER - IRF	0	0				
42.00	SUBPROVIDER	0	0				
43.00	NURSERY	0	0				
44.00	SKILLED NURSING FACILITY	0	0				
45.00	NURSING FACILITY	0	0				
200.00	Total (lines 30 through 199)	0	0				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 26-3304		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part II Date/Time Prepared: 5/23/2019 12:47 pm	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital TEFRA								
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	237,320	11,046,318	0.021484	0	0	50.00
51.00	05100	RECOVERY ROOM	103,412	1,875,289	0.055145	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	24,046	3,703,571	0.006493	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	154,976	2,631,722	0.058888	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	72,315	193,741	0.373256	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	29,987	733,504	0.040882	0	0	65.00
66.00	06600	PHYSICAL THERAPY	119,184	1,604,807	0.074267	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	75,045	579,564	0.129485	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,949	1,538,837	0.016863	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	337,742	7,453,464	0.045313	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	56,228	2,219,124	0.025338	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	168,539	1,579,319	0.106716	0	0	90.00
91.00	09100	EMERGENCY	0	0	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	592	3,765	0.157238	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00		Total (lines 50 through 199)	1,405,335	35,163,025		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 26-3304	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part III Date/Time Prepared: 5/23/2019 12:47 pm
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Cost Center Description		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
		1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
40.00	04000	SUBPROVIDER - I PF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
200.00		Total (lines 30 through 199)	0	0	0	0	200.00
Cost Center Description		Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
		4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	1,109	0.00	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0.00	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0.00	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0.00	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0.00	34.00
40.00	04000	SUBPROVIDER - I PF	0	0	0	0.00	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0.00	41.00
42.00	04200	SUBPROVIDER	0	0	0	0.00	42.00
43.00	04300	NURSERY	0	0	0	0.00	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0.00	44.00
45.00	04500	NURSING FACILITY	0	0	0	0.00	45.00
200.00		Total (lines 30 through 199)	0	0	1,109	0	200.00
Cost Center Description		Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
		9.00					
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0				30.00
31.00	03100	INTENSIVE CARE UNIT	0				31.00
32.00	03200	CORONARY CARE UNIT	0				32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0				33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0				34.00
40.00	04000	SUBPROVIDER - I PF	0				40.00
41.00	04100	SUBPROVIDER - I RF	0				41.00
42.00	04200	SUBPROVIDER	0				42.00
43.00	04300	NURSERY	0				43.00
44.00	04400	SKILLED NURSING FACILITY	0				44.00
45.00	04500	NURSING FACILITY	0				45.00
200.00		Total (lines 30 through 199)	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 26-3304	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/23/2019 12:47 pm
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Cost Center Description	Title XVIII				Hospital		Allied Health
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	TEFRA	
	1.00	2A	2.00	3A	3.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	0	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
90.00 09000 CLINIC	0	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	0	94.00
95.00 09500 AMBULANCE SERVICES	0	0	0	0	0	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	0	98.00
200.00 Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 26-3304	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/23/2019 12:47 pm
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Cost Center Description		Title XVIII			Hospital		TEFRA	
		All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	11,046,318	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,875,289	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,703,571	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,631,722	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	193,741	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0.000000	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0.000000	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	733,504	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,604,807	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	579,564	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,538,837	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,453,464	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,219,124	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	1,579,319	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,765	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0.000000	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0.000000	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0.000000	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0.000000	98.00
200.00		Total (lines 50 through 199)	0	0	0	35,163,025		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 26-3304	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/23/2019 12:47 pm
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Cost Center Description		Title XVIII				Hospital	
		Outpatient Ratio of Cost to Charges (col. 6 + col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	TEFRA
		9.00	10.00	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400 HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00
95.00	09500 AMBULANCE SERVICES	0.000000	0	0	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00	Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 26-3304	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/23/2019 12:47 pm
		Title XVIII	Hospital	TEFRA

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0.218296	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.722292	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.090890	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.392615	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	06000 LABORATORY	1.891009	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.573626	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.742377	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	1.122753	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.276372	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.774023	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.350220	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0.000000				88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
90.00	09000 CLINIC	0.671845	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.701726	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00	09400 HOME PROGRAM DIALYSIS	0.000000		0		94.00
95.00	09500 AMBULANCE SERVICES	0.000000		0		95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	97.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	98.00
200.00	Subtotal (see instructions)		0	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 - line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 26-3304	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/23/2019 12:47 pm
	Title XVIII	Hospital	TEFRA

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00 05600 RADIOISOTOPE	0	0		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
94.00 09400 HOME PROGRAM DIALYSIS	0	0		94.00
95.00 09500 AMBULANCE SERVICES	0	0		95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00 Subtotal (see instructions)	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0	0		201.00
202.00 Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 26-3304	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part III Date/Time Prepared: 5/23/2019 12:47 pm
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Cost Center Description		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
		1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
200.00		Total (lines 30 through 199)	0	0	0	0	200.00
Cost Center Description		Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
		4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	1,109	0.00	27
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0.00	0
32.00	03200	CORONARY CARE UNIT	0	0	0	0.00	0
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0.00	0
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0.00	0
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0
42.00	04200	SUBPROVIDER	0	0	0	0.00	0
43.00	04300	NURSERY	0	0	0	0.00	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0.00	0
45.00	04500	NURSING FACILITY	0	0	0	0.00	0
200.00		Total (lines 30 through 199)	0	0	1,109	0.00	27
Cost Center Description		Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
		9.00					
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0				30.00
31.00	03100	INTENSIVE CARE UNIT	0				31.00
32.00	03200	CORONARY CARE UNIT	0				32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0				33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0				34.00
40.00	04000	SUBPROVIDER - IPF	0				40.00
41.00	04100	SUBPROVIDER - IRF	0				41.00
42.00	04200	SUBPROVIDER	0				42.00
43.00	04300	NURSERY	0				43.00
44.00	04400	SKILLED NURSING FACILITY	0				44.00
45.00	04500	NURSING FACILITY	0				45.00
200.00		Total (lines 30 through 199)	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 26-3304	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/23/2019 12:47 pm
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Cost Center Description	Title XIX				Hospital		Allied Health Cost
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
	1.00	2A	2.00	3A	3.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-3304

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/23/2019 12:47 pm

Cost Center Description		Title XIX			Hospital	Cost		
		All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	11,046,318	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,875,289	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,703,571	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,631,722	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	193,741	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0.000000	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0.000000	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	733,504	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,604,807	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	579,564	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,538,837	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,453,464	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,219,124	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	1,579,319	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,765	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0.000000	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0.000000	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0.000000	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0.000000	98.00
200.00		Total (lines 50 through 199)	0	0	0	35,163,025		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 26-3304	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/23/2019 12:47 pm
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Cost Center Description		Title XIX			Hospital		Cost
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.000000	121,016	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	15,324	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	38,714	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	5,742	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	887	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	12,184	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	11,994	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	12,426	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	242,063	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	24,566	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400 HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00
95.00	09500 AMBULANCE SERVICES	0.000000	0	0	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00	Total (lines 50 through 199)		484,916	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 26-3304	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/23/2019 12:47 pm
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Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
		1.00	2.00	3.00	4.00	5.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0.218296	0	0	275,527	0
51.00	05100 RECOVERY ROOM	0.722292	0	0	54,844	0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0
53.00	05300 ANESTHESIOLOGY	0.090890	0	0	98,686	0
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.392615	0	0	12,461	0
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0
57.00	05700 CT SCAN	0.000000	0	0	0	0
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00	06000 LABORATORY	1.891009	0	0	185	0
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	0
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0
65.00	06500 RESPIRATORY THERAPY	0.573626	0	0	2,246	0
66.00	06600 PHYSICAL THERAPY	0.742377	0	0	2,245	0
67.00	06700 OCCUPATIONAL THERAPY	1.122753	0	0	954	0
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.276372	0	0	2,100	0
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.774023	0	0	49,369	0
73.00	07300 DRUGS CHARGED TO PATIENTS	0.350220	0	0	29,535	0
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0.000000				0
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0
90.00	09000 CLINIC	0.671845	0	0	2,164	0
91.00	09100 EMERGENCY	0.000000	0	0	0	0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.701726	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00	09400 HOME PROGRAM DIALYSIS	0.000000		0		94.00
95.00	09500 AMBULANCE SERVICES	0.000000	0	0		95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0
200.00	Subtotal (see instructions)		0	0	530,316	0
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 - line 201)		0	0	530,316	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 26-3304	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/23/2019 12:47 pm
	Title XIX	Hospital	Cost

Cost Center Description	Costs		Hospital	Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	60,146		50.00
51.00 05100 RECOVERY ROOM	0	39,613		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	8,970		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	4,892		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00 05600 RADIOISOTOPE	0	0		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	350		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	1,288		65.00
66.00 06600 PHYSICAL THERAPY	0	1,667		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	1,071		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	580		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	38,213		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	10,344		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00 09000 CLINIC	0	1,454		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
94.00 09400 HOME PROGRAM DIALYSIS	0	0		94.00
95.00 09500 AMBULANCE SERVICES	0	0		95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00 Subtotal (see instructions)	0	168,588		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	0	168,588		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-3304	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/23/2019 12:47 pm
Cost Center Description		Title XVIII	Hospital	TEFRA
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,109	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,109	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,107	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,552,884	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,552,884	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,552,884	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		3,203.68	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		0	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		0	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 26-3304		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/23/2019 12:47 pm	
Cost Center Description			Title XVIII		Hospital		TEFRA	
			Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
			1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)		0	0	0.00	0		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		0	0	0.00	0		44.00
45.00	BURN INTENSIVE CARE UNIT		0	0	0.00	0		45.00
46.00	SURGICAL INTENSIVE CARE UNIT		0	0	0.00	0		46.00
47.00	OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)							48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)							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)							50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)							51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)							52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)							53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges							54.00
55.00	Target amount per discharge						0.00	55.00
56.00	Target amount (line 54 x line 55)							56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							57.00
58.00	Bonus payment (see instructions)							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)							61.00
62.00	Relief payment (see instructions)							62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)							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)							64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)							65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)							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)							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)							68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							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)						2	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						3,203.68	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						6,407	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-3304		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/23/2019 12:47 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	328,555	3,552,884	0.092476	6,407	592	90.00
91.00	Nursing School cost	0	3,552,884	0.000000	6,407	0	91.00
92.00	Allied health cost	0	3,552,884	0.000000	6,407	0	92.00
93.00	All other Medical Education	0	3,552,884	0.000000	6,407	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-3304	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/23/2019 12:47 pm
Cost Center Description		Title XIX	Hospital	Cost
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,109	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,109	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,107	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)		27	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
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,552,884	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,552,884	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,552,884	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		3,203.68	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		86,499	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)		86,499	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 26-3304	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/23/2019 12:47 pm	
Cost Center Description			Title XIX	Hospital	Cost	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	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	0	0	0.00	0	44.00
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	45.00
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						
					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				260,228	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				346,727	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0
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	55.00
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	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
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)				2	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				3,203.68	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				6,407	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-3304		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/23/2019 12:47 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	328,555	3,552,884	0.092476	6,407	592	90.00
91.00	Nursing School cost	0	3,552,884	0.000000	6,407	0	91.00
92.00	Allied health cost	0	3,552,884	0.000000	6,407	0	92.00
93.00	All other Medical Education	0	3,552,884	0.000000	6,407	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 26-3304	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/23/2019 12:47 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		57,465	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
32.00	03200	CORONARY CARE UNIT		0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	34.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.218296	121,016	50.00
51.00	05100	RECOVERY ROOM	0.722292	15,324	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.090890	38,714	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.392615	5,742	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	56.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	1.891009	887	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.573626	12,184	65.00
66.00	06600	PHYSICAL THERAPY	0.742377	11,994	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.122753	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.276372	12,426	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.774023	242,063	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.350220	24,566	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	0.671845	0	90.00
91.00	09100	EMERGENCY	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.701726	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	94.00
95.00	09500	AMBULANCE SERVICES			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	97.00
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)		484,916	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)		484,916	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-3304	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/23/2019 12:47 pm
		Title XVIII	Hospital	TEFRA
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		0	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		0	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		0	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		0	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 26-3304

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/23/2019 12:47 pm

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 26-3304	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/23/2019 12:47 pm
		Title XVIII	Hospital	TEFRA
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
<b>INPATIENT HOSPITAL SERVICES UNDER THE IPPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-3304	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part I Date/Time Prepared: 5/23/2019 12:47 pm
		Title XVIII	Hospital	TEFRA
				1.00
<b>PART I - MEDICARE PART A SERVICES - TEFRA</b>				
1.00	Inpatient hospital services (see instructions)			0 1.00
1.01	Nursing and allied health managed care payment (see instructions)			0 1.01
2.00	Organ acquisition			0 2.00
3.00	Cost of physicians' services in a teaching hospital (see instructions)			0 3.00
4.00	Subtotal (sum of lines 1 through 3)			0 4.00
5.00	Primary payer payments			0 5.00
6.00	Subtotal (line 4 less line 5)			0 6.00
7.00	Deductibles			0 7.00
8.00	Subtotal (line 6 minus line 7)			0 8.00
9.00	Coinsurance			0 9.00
10.00	Subtotal (line 8 minus line 9)			0 10.00
11.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 11.00
12.00	Adjusted reimbursable bad debts (see instructions)			0 12.00
13.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 13.00
14.00	Subtotal (sum of lines 10 and 12)			0 14.00
15.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 15.00
16.00	DO NOT USE THIS LINE			0 16.00
17.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 17.00
17.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 17.50
17.99	Demonstration payment adjustment amount before sequestration			0 17.99
18.00	Total amount payable to the provider (see instructions)			0 18.00
18.01	Sequestration adjustment (see instructions)			0 18.01
18.02	Demonstration payment adjustment amount after sequestration			0 18.02
19.00	Interim payments			0 19.00
20.00	Tentative settlement (for contractor use only)			0 20.00
21.00	Balance due provider/program (line 18 minus lines 18.01, 18.02, 19, and 20)			0 21.00
22.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 22.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-3304	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part VII Date/Time Prepared: 5/23/2019 12:47 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		346,727		1.00
2.00	Medical and other services			168,588	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		346,727	168,588	4.00
5.00	Inpatient primary payer payments		57,471		5.00
6.00	Outpatient primary payer payments			41,975	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		289,256	126,613	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		57,465		8.00
9.00	Ancillary service charges		484,916	530,316	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)		542,381	530,316	12.00
<b>CUSTOMARY CHARGES</b>					
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)		542,381	530,316	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		195,654	361,728	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		346,727	168,588	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
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)		346,727	168,588	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		289,256	126,613	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		289,256	126,613	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		289,256	126,613	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)		289,256	126,613	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		289,256	126,613	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 26-3304

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

Worksheet G

Date/Time Prepared:  
5/23/2019 12:47 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	148,175	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	8,184,969	0	0	0	4.00
5.00	Other receivable	416	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-7,231,895	0	0	0	6.00
7.00	Inventory	553,742	0	0	0	7.00
8.00	Prepaid expenses	280,446	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)	1,935,853	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	4,154,898	0	0	0	12.00
13.00	Land improvements	300,027	0	0	0	13.00
14.00	Accumulated depreciation	-298,752	0	0	0	14.00
15.00	Buildings	40,275,038	0	0	0	15.00
16.00	Accumulated depreciation	-5,548,044	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	577,019	0	0	0	19.00
20.00	Accumulated depreciation	-130,675	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	10,869,034	0	0	0	23.00
24.00	Accumulated depreciation	-7,005,412	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)	43,193,133	0	0	0	30.00
<b>OTHER ASSETS</b>						
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	4,412,046	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,412,046	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	49,541,032	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	2,173,332	0	0	0	37.00
38.00	Salaries, wages, and fees payable	954,867	0	0	0	38.00
39.00	Payroll taxes payable	30,787	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	1,065,239	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,224,225	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	4,224,225	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	45,316,809				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)	45,316,809	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	49,541,034	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 26-3304

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

Worksheet G-1

Date/Time Prepared:  
5/23/2019 12:47 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		18,634,928		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-10,998,888			2.00
3.00	Total (sum of line 1 and line 2)		7,636,040		0	3.00
4.00	Additions (credit adjustments) (specify)	37,680,769		0		4.00
5.00		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)		37,680,769		0	10.00
11.00	Subtotal (line 3 plus line 10)		45,316,809		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		45,316,809		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 26-3304

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/23/2019 12:47 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	2,330,994		2,330,994	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE	0		0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,330,994		2,330,994	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT	0		0	12.00
13.00	BURN INTENSIVE CARE UNIT	0		0	13.00
14.00	SURGICAL INTENSIVE CARE UNIT	0		0	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,330,994		2,330,994	17.00
18.00	Ancillary services	20,496,487	21,314,298	41,810,785	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY	0	0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC	0	0	0	24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	25.00
26.00	HOSPICE	0	0	0	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	22,827,481	21,314,298	44,141,779	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		32,008,405		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)		32,008,405		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 26-3304

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

Worksheet G-3

Date/Time Prepared:  
5/23/2019 12:47 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	44,141,779	1.00
2.00	Less contractual allowances and discounts on patients' accounts	36,758,530	2.00
3.00	Net patient revenues (line 1 minus line 2)	7,383,249	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	32,008,405	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-24,625,156	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	7,204,780	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	47	10.00
11.00	Rebates and refunds of expenses	1,707	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	158,044	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	3,209	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	5,655,413	23.00
24.00	OTHER INCOME	178,395	24.00
24.01	GRANT INCOME	424,673	24.01
24.02	OTHER (SPECIFY)	0	24.02
25.00	Total other income (sum of lines 6-24)	13,626,268	25.00
26.00	Total (line 5 plus line 25)	-10,998,888	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-10,998,888	29.00