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: 26-0104	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/22/2018 1:19 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/22/2018 Time: 1:19 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] 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. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] 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 SSM HEALTH DEPAUL HOSPITAL (26-0104) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[X] 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) KAREN REWERTS
Officer or Administrator of Provider(s)

SYSTEM VP OF FINANCE
Title

(Dated when report is electronically signed.)
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	85,926	28,649	0	0	1.00
2.00	Subprovider - IPF	0	18,223	11		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	Total	0	104,149	28,660	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/16/2018 8:40 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 12303 DEPAUL DRIVE	PO Box:			1.00
2.00	City: BRIDGETON	State: MO	Zip Code: 63044	County: ST. LOUIS	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	SSM HEALTH DEPAUL HOSPITAL	260104	41180	1	01/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	SSM HEALTH DEPAUL HOSPITAL	26S104	41180	4	07/01/1985	N	P	O	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	SSM HEALTH DEPAUL HOSPITAL-ANN HOUSE	265842	41180		09/11/2012	N	P	P	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2017	12/31/2017	20.00
21.00	Type of Control (see instructions)	1		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	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)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	16,994	3,972	484	605	7,307	297	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/16/2018 8:40 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	Y	Y	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	Y			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	Y			60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1	60.01

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/16/2018 8:40 am

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	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.				
64.00	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

	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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/16/2018 8:40 am

		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	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N		0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 26-0104	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/16/2018 8:40 am

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			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.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

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		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1,430,493	9,797	0	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.	Y	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	269020	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/16/2018 8:40 am

	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: SSM HEALTH CARE CORP	Contractor's Name: WPS	Contractor's Number: 05301	141.00
142.00	Street: 10101 WOODFIELD LANE	PO Box: PO BOX 86		142.00
143.00	City: ST. LOUIS	State: MO	Zip Code: 63132	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		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)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/02/2017	12/30/2017	170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 5/16/2018 8:40 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	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?		Y	Y	6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		Y		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.		Y		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.		Y		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.		Y		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	04/04/2018	Y	04/04/2018
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	
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	
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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 5/16/2018 8:40 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ERIC	LAMOND	41.00
42.00	Enter the employer/company name of the cost report preparer.	SSM HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-989-3162	ERIC.LAMOND@SSMHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 26-0104	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/16/2018 8:40 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER - GOVERNMENT REIMBURSEMENT		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: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I Date/Time Prepared: 5/16/2018 8:40 am

	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	386	140,890	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)		386	140,890	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	44	16,060	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		430	156,950	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	25	9,125		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	52	18,980		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		507				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: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/16/2018 8:40 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	31,184	14,955	91,366			1.00
2.00	HMO and other (see instructions)	20,426	12,368				2.00
3.00	HMO IPF Subprovider	0	180				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	31,184	14,955	91,366			7.00
8.00	INTENSIVE CARE UNIT	1,677	1,699	13,204			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		340	2,837			13.00
14.00	Total (see instructions)	32,861	16,994	107,407	15.00	1,924.57	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,777	2,078	4,912	0.00	109.31	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	2,913	11,826	16,890	0.00	65.01	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				15.00	2,098.89	27.00
28.00	Observation Bed Days		633	8,023			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			1,359			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	297	377			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: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/16/2018 8:40 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	6,490	2,388	21,873	1.00
2.00	HMO and other (see instructions)			4,088	2,147		2.00
3.00	HMO IPF Subprovider				45		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	6,490	2,388	21,873	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	206	243	765	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part II Date/Time Prepared: 5/16/2018 8:40 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	130,589,286	0	130,589,286	4,755,353.48	27.46	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		370,463	0	370,463	2,433.70	152.22	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		3,928,104	0	3,928,104	22,119.73	177.58	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	906,050	0	906,050	32,056.74	28.26	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	2,426,806	0	2,426,806	135,230.70	17.95	9.00
10.00	Excluded area salaries (see instructions)		7,576,753	-5,303,271	2,273,482	96,789.20	23.49	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		5,800,573	0	5,800,573	107,095.12	54.16	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		518,547	0	518,547	3,931.75	131.89	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		15,103,535	0	15,103,535	422,840.19	35.72	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		52,735,026	0	52,735,026			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		925,851	0	925,851			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		25,904	0	25,904			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		157,936	0	157,936			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		65,187	0	65,187			25.00
25.50	Home office wage-related (core)		5,347,835	0	5,347,835			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	273,017	0	273,017	12,097.85	22.57	26.00
27.00	Administrative & General	5.00	12,214,126	-312,842	11,901,284	364,713.13	32.63	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part II Date/Time Prepared: 5/16/2018 8:40 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		825,921	0	825,921	5,317.50	155.32	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,794,693	0	1,794,693	70,772.95	25.36	30.00
31.00	Laundry & Linen Service	8.00	167,244	0	167,244	13,354.56	12.52	31.00
32.00	Housekeeping	9.00	2,861,325	0	2,861,325	223,668.48	12.79	32.00
33.00	Housekeeping under contract (see instructions)		360,546	0	360,546	12,979.03	27.78	33.00
34.00	Dietary	10.00	2,690,508	0	2,690,508	203,098.22	13.25	34.00
35.00	Dietary under contract (see instructions)		429,423	0	429,423	15,458.00	27.78	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	3,044,182	0	3,044,182	98,197.73	31.00	38.00
39.00	Central Services and Supply	14.00	306,513	312,842	619,355	37,172.16	16.66	39.00
40.00	Pharmacy	15.00	5,142,487	146,051	5,288,538	141,774.77	37.30	40.00
41.00	Medical Records & Medical Records Library	16.00	463,436	0	463,436	28,659.05	16.17	41.00
42.00	Social Service	17.00	456,177	0	456,177	16,914.19	26.97	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part III Date/Time Prepared: 5/16/2018 8:40 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		127,371,022	0	127,371,022	4,734,931.54	26.90	1.00
2.00	Excluded area salaries (see instructions)		10,003,559	-5,303,271	4,700,288	232,019.90	20.26	2.00
3.00	Subtotal salaries (line 1 minus line 2)		117,367,463	5,303,271	122,670,734	4,502,911.64	27.24	3.00
4.00	Subtotal other wages & related costs (see inst.)		21,422,655	0	21,422,655	533,867.06	40.13	4.00
5.00	Subtotal wage-related costs (see inst.)		58,108,765	0	58,108,765	0.00	47.37	5.00
6.00	Total (sum of lines 3 thru 5)		196,898,883	5,303,271	202,202,154	5,036,778.70	40.15	6.00
7.00	Total overhead cost (see instructions)		31,029,598	146,051	31,175,649	1,244,177.62	25.06	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part IV Date/Time Prepared: 5/16/2018 8:40 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,840,399	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	13,832,315	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	17,086,596	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	6,488,261	9.00
10.00	Dental, Hearing and Vision Plan	1,348,266	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	393,684	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	479,619	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	2,263,704	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	8,676,668	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	61,120	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	904,694	22.00
23.00	Tuition Reimbursement	534,577	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	53,909,903	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part V Date/Time Prepared: 5/16/2018 8:40 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	6,971,186	53,909,903	1.00
2.00	Hospital	5,800,573	52,735,026	2.00
3.00	Subprovider - IPF	307,946	925,851	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	862,667	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	249,026	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-7 | Date/Time Prepared: 5/16/2018 8:40 am

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.			2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	475	0	475	12.00
13.00		RUB	1,081	0	1,081	13.00
14.00		RUA	490	0	490	14.00
15.00		RVC	320	0	320	15.00
16.00		RVB	308	0	308	16.00
17.00		RVA	156	0	156	17.00
18.00		RHC	0	0	0	18.00
19.00		RHB	8	0	8	19.00
20.00		RHA	7	0	7	20.00
21.00		RMC	17	0	17	21.00
22.00		RMB	0	0	0	22.00
23.00		RMA	0	0	0	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	3	0	3	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	0	0	0	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	4	0	4	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	7	0	7	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	2	0	2	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	6	0	6	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-7 | Date/Time Prepared: 5/16/2018 8:40 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	11	0	11	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	15	0	15	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	3	0	3	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		2,913	0	2,913	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	41180	41180	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	4,253,608			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-10 | Date/Time Prepared: 5/16/2018 8:40 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.245300	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	39,479,343	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	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	195,523,005	6.00
7.00	Medicaid cost (line 1 times line 6)	47,961,793	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)	8,482,450	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	8,482,450	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	61,620,595	3,766,969	65,387,564	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	15,115,532	3,766,969	18,882,501	21.00
22.00	Payments received from patients for amounts previously written off as charity care	468,524	179,957	648,481	22.00
23.00	Cost of charity care (line 21 minus line 22)	14,647,008	3,587,012	18,234,020	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)	28,091,758	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	2,011,566	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	3,094,717	27.01
28.00	Non-Medicare bad debt expense (see instructions)	24,997,041	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	7,214,925	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	25,448,945	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	33,931,395	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/16/2018 8:40 am

		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	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		8,043,694	8,043,694	-52,781	7,990,913	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		6,023,550	6,023,550	0	6,023,550	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	273,017	34,141,444	34,414,461	52,781	34,467,242	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,214,126	82,155,962	94,370,088	-1,162,920	93,207,168	5.00
7.00	00700	OPERATION OF PLANT	1,794,693	9,472,941	11,267,634	0	11,267,634	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	167,244	843,519	1,010,763	0	1,010,763	8.00
9.00	00900	HOUSEKEEPING	2,861,325	1,480,782	4,342,107	0	4,342,107	9.00
10.00	01000	DIETARY	2,690,508	4,107,405	6,797,913	0	6,797,913	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,044,182	419,719	3,463,901	0	3,463,901	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	306,513	1,284,788	1,591,301	1,162,920	2,754,221	14.00
15.00	01500	PHARMACY	5,142,487	32,666,684	37,809,171	-31,511,057	6,298,114	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	463,436	487,967	951,403	0	951,403	16.00
17.00	01700	SOCIAL SERVICE	456,177	214,770	670,947	0	670,947	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	906,050	80,353	986,403	-80,353	906,050	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	80,353	80,353	22.00
23.00	02300	PHARMACY RESIDENCY PROGRAM	277,570	16,491	294,061	-146,051	148,010	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	36,402,396	5,260,351	41,662,747	354,273	42,017,020	30.00
31.00	03100	INTENSIVE CARE UNIT	7,558,744	4,483,755	12,042,499	-1,470,251	10,572,248	31.00
40.00	04000	SUBPROVIDER - IPF	7,095,485	1,944,905	9,040,390	-6,656,410	2,383,980	40.00
43.00	04300	NURSERY	219,691	209	219,900	497,727	717,627	43.00
44.00	04400	SKILLED NURSING FACILITY	2,426,806	2,301,370	4,728,176	-253,708	4,474,468	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,731,732	26,359,297	35,091,029	-21,392,044	13,698,985	50.00
51.00	05100	RECOVERY ROOM	1,045,689	52,284	1,097,973	-35,194	1,062,779	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,329,669	2,329,669	52.00
52.01	05201	PERINATAL CLINIC	551,527	841,850	1,393,377	-11,246	1,382,131	52.01
53.00	05300	ANESTHESIOLOGY	73,031	3,960,278	4,033,309	-548,550	3,484,759	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,805,516	8,126,728	11,932,244	-3,902,205	8,030,039	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,088,414	803,182	2,891,596	-18,370	2,873,226	55.00
56.00	05600	RADIOISOTOPE	293,918	710,282	1,004,200	-5,477	998,723	56.00
57.00	05700	CT SCAN	812,689	625,999	1,438,688	-183,520	1,255,168	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	400,402	105,323	505,725	-20,295	485,430	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,326,770	11,599,490	12,926,260	-10,547,044	2,379,216	59.00
60.00	06000	LABORATORY	2,208,344	3,377,712	5,586,056	-23,041	5,563,015	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	494,290	1,444,313	1,938,603	1,115,655	3,054,258	62.00
64.00	06400	INTRAVENOUS THERAPY	1,803,459	753,534	2,556,993	-266,762	2,290,231	64.00
65.00	06500	RESPIRATORY THERAPY	2,436,828	1,349,344	3,786,172	-330,988	3,455,184	65.00
66.00	06600	PHYSICAL THERAPY	0	2,232,554	2,232,554	-17,614	2,214,940	66.00
66.01	06601	CLINICAL NUTRITION	751,555	2,945	754,500	-26	754,474	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	1,026,597	1,026,597	-21,468	1,005,129	67.00
68.00	06800	SPEECH PATHOLOGY	0	449,923	449,923	-17	449,906	68.00
69.00	06900	ELECTROCARDIOLOGY	2,698,932	1,657,764	4,356,696	-857,301	3,499,395	69.00
69.01	06901	CARDIAC REHABILITATION	649,954	15,790	665,744	-3,035	662,709	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	265,302	196,484	461,786	-54,043	407,743	70.00
70.01	07001	ELECTROSHOCK THERAPY	88,737	16,752	105,489	-14,085	91,404	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	23,707,903	23,707,903	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	20,523,052	20,523,052	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	30,738,558	30,738,558	73.00
74.00	07400	RENAL DIALYSIS	15	1,638,947	1,638,962	-52,433	1,586,529	74.00
76.00	03330	ENDOSCOPY	974,944	984,844	1,959,788	-564,157	1,395,631	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,577,630	5,166,911	10,744,541	724,142	11,468,683	90.00
91.00	09100	EMERGENCY	9,005,460	2,889,770	11,895,230	-1,084,585	10,810,645	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	130,385,588	271,819,556	402,205,144	2	402,205,146	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	51,567	51,127	102,694	0	102,694	190.00
191.00	19100	RESEARCH	92,193	0	92,193	0	92,193	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	NON-REIMBURSABLE	59,938	7,413	67,351	-2	67,349	194.00
194.01	07950	RETAIL PHARMACY	0	7,727,269	7,727,269	0	7,727,269	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	130,589,286	279,605,365	410,194,651	0	410,194,651	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/16/2018 8:40 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	425,497	8,416,410		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	859,396	6,882,946		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-3,519,172	30,948,070		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-14,956,095	78,251,073		5.00
7.00	00700	OPERATION OF PLANT	-1,553,265	9,714,369		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,010,763		8.00
9.00	00900	HOUSEKEEPING	0	4,342,107		9.00
10.00	01000	DIETARY	-1,790,834	5,007,079		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	-2,538	3,461,363		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,754,221		14.00
15.00	01500	PHARMACY	-12,018	6,286,096		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,668	948,735		16.00
17.00	01700	SOCIAL SERVICE	-77,757	593,190		17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	906,050		21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	80,353		22.00
23.00	02300	PHARMACY RESIDENCY PROGRAM	-12,500	135,510		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-7,574,870	34,442,150		30.00
31.00	03100	INTENSIVE CARE UNIT	-2,618,396	7,953,852		31.00
40.00	04000	SUBPROVIDER - IPF	-1,097,149	1,286,831		40.00
43.00	04300	NURSERY	0	717,627		43.00
44.00	04400	SKILLED NURSING FACILITY	-423,079	4,051,389		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-29,285	13,669,700		50.00
51.00	05100	RECOVERY ROOM	-20	1,062,759		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,329,669		52.00
52.01	05201	PERINATAL CLINIC	-733,040	649,091		52.01
53.00	05300	ANESTHESIOLOGY	-2,806,069	678,690		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-490,276	7,539,763		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-25,969	2,847,257		55.00
56.00	05600	RADIOISOTOPE	-313	998,410		56.00
57.00	05700	CT SCAN	-58,552	1,196,616		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-25,824	459,606		58.00
59.00	05900	CARDIAC CATHETERIZATION	-9,077	2,370,139		59.00
60.00	06000	LABORATORY	-2,181,528	3,381,487		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	-81,551	2,972,707		62.00
64.00	06400	INTRAVENOUS THERAPY	-77,829	2,212,402		64.00
65.00	06500	RESPIRATORY THERAPY	-12,473	3,442,711		65.00
66.00	06600	PHYSICAL THERAPY	-80	2,214,860		66.00
66.01	06601	CLINICAL NUTRITION	-74,817	679,657		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	1,005,129		67.00
68.00	06800	SPEECH PATHOLOGY	0	449,906		68.00
69.00	06900	ELECTROCARDIOLOGY	-328,630	3,170,765		69.00
69.01	06901	CARDIAC REHABILITATION	-1,038	661,671		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	-451	407,292		70.00
70.01	07001	ELECTROSHOCK THERAPY	0	91,404		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-232,733	23,475,170		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	20,523,052		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	30,738,558		73.00
74.00	07400	RENAL DIALYSIS	-1,723	1,584,806		74.00
76.00	03330	ENDOSCOPY	-1,166	1,394,465		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-2,972,895	8,495,788		90.00
91.00	09100	EMERGENCY	-1,424,227	9,386,418		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-43,925,014	358,280,132		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	102,694		190.00
191.00	19100	RESEARCH	0	92,193		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07951	NON-REIMBURSABLE	0	67,349		194.00
194.01	07950	RETAIL PHARMACY	0	7,727,269		194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-43,925,014	366,269,637		200.00

RECLASSIFICATIONS | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/16/2018 8:40 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - PHARMACY RECLASS					
1.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	0	1,117,355		1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	30,738,558		2.00
	0		0	31,855,913		
	B - NURSERY & L&D					
1.00	NURSERY	43.00	427,056	70,880		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1,998,046	331,623		2.00
	0		2,425,102	402,503		
	C - CENTRAL SUPPLY					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	23,707,903		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	20,523,052		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
	0		0	44,230,955		
	D - BHM - DEPT					
1.00	ADULTS & PEDIATRICS	30.00	1,396,392	760,129		1.00
	0		1,396,392	760,129		
	E - BHM - ADMIN					
1.00	ADULTS & PEDIATRICS	30.00	3,090,119	569,311		1.00
2.00	CLINIC	90.00	670,709	123,569		2.00
	0		3,760,828	692,880		
	F - PARKING GARAGE					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	52,781		1.00
	0		0	52,781		
	G - CENTRAL DISTRIBUTION					
1.00	CENTRAL SERVICES & SUPPLY	14.00	312,842	850,078		1.00
	0		312,842	850,078		
	H - RESIDENCY ANCILLARY					
1.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	0	80,353		1.00
	0		0	80,353		
	I - PHARMACY RESIDENCY					
1.00	PHARMACY	15.00	146,051	0		1.00
	TOTALS		146,051	0		
500.00	Grand Total: Increases		8,041,215	78,925,592		500.00

RECLASSIFICATIONS | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/16/2018 8:40 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - PHARMACY RECLASS						
1.00	PHARMACY	15.00	0	31,657,108	0		1.00
2.00	SKILLED NURSING FACILITY	44.00	0	198,805	0		2.00
	0		0	31,855,913			
	B - NURSERY & L&D						
1.00	ADULTS & PEDIATRICS	30.00	2,425,102	402,503	0		1.00
2.00		0.00	0	0	0		2.00
	0		2,425,102	402,503			
	C - CENTRAL SUPPLY						
1.00	ADULTS & PEDIATRICS	30.00	0	2,634,073	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	1,470,251	0		2.00
3.00	SUBPROVIDER - IPF	40.00	0	46,181	0		3.00
4.00	NURSERY	43.00	0	209	0		4.00
5.00	SKILLED NURSING FACILITY	44.00	0	54,903	0		5.00
6.00	OPERATING ROOM	50.00	0	21,392,044	0		6.00
7.00	RECOVERY ROOM	51.00	0	35,194	0		7.00
8.00	PERINATAL CLINIC	52.01	0	11,246	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	548,550	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,902,205	0		10.00
11.00	RADIOLOGY-THERAPEUTIC	55.00	0	18,370	0		11.00
12.00	RADIOISOTOPE	56.00	0	5,477	0		12.00
13.00	CT SCAN	57.00	0	183,520	0		13.00
14.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	20,295	0		14.00
15.00	CARDIAC CATHETERIZATION	59.00	0	10,547,044	0		15.00
16.00	LABORATORY	60.00	0	23,041	0		16.00
17.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	0	1,700	0		17.00
18.00	INTRAVENOUS THERAPY	64.00	0	266,762	0		18.00
19.00	RESPIRATORY THERAPY	65.00	0	330,988	0		19.00
20.00	PHYSICAL THERAPY	66.00	0	17,614	0		20.00
21.00	CLINICAL NUTRITION	66.01	0	26	0		21.00
22.00	OCCUPATIONAL THERAPY	67.00	0	21,468	0		22.00
23.00	SPEECH PATHOLOGY	68.00	0	17	0		23.00
24.00	ELECTROCARDIOLOGY	69.00	0	857,301	0		24.00
25.00	CARDIAC REHABILITATION	69.01	0	3,035	0		25.00
26.00	ELECTROENCEPHALOGRAPHY	70.00	0	54,043	0		26.00
27.00	ELECTROSHOCK THERAPY	70.01	0	14,085	0		27.00
28.00	RENAL DIALYSIS	74.00	0	52,433	0		28.00
29.00	ENDOSCOPY	76.00	0	564,157	0		29.00
30.00	CLINIC	90.00	0	70,136	0		30.00
31.00	EMERGENCY	91.00	0	1,084,585	0		31.00
32.00	NON-REIMBURSABLE	194.00	0	2	0		32.00
	0		0	44,230,955			
	D - BHM - DEPT						
1.00	SUBPROVIDER - IPF	40.00	1,396,392	760,129	0		1.00
	0		1,396,392	760,129			
	E - BHM - ADMIN						
1.00	SUBPROVIDER - IPF	40.00	3,760,828	692,880	0		1.00
2.00		0.00	0	0	0		2.00
	0		3,760,828	692,880			
	F - PARKING GARAGE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	52,781	9		1.00
	0		0	52,781			
	G - CENTRAL DISTRIBUTION						
1.00	ADMINISTRATIVE & GENERAL	5.00	312,842	850,078	0		1.00
	0		312,842	850,078			
	H - RESIDENCY ANCILLARY						
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	80,353	0		1.00
	0		0	80,353			
	I - PHARMACY RESIDENCY						
1.00	PHARMACY RESIDENCY PROGRAM	23.00	146,051	0	0		1.00
	TOTALS		146,051	0			
500.00	Grand Total: Decreases		8,041,215	78,925,592			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 5/16/2018 8:40 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	9,615,392	0	0	0	0	1.00
2.00	Land Improvements	3,981,052	31,216	0	31,216	1,146,909	2.00
3.00	Buildings and Fixtures	94,070,363	9,494,293	0	9,494,293	1,681,593	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	3,264,436	439,763	0	439,763	17,605	5.00
6.00	Movable Equipment	80,080,705	4,446,976	22,694	4,469,670	1,600,414	6.00
7.00	HIT designated Assets	201,582	56,646	0	56,646	-753,061	7.00
8.00	Subtotal (sum of lines 1-7)	191,213,530	14,468,894	22,694	14,491,588	3,693,460	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	191,213,530	14,468,894	22,694	14,491,588	3,693,460	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	9,615,392	0	1.00
2.00	Land Improvements	2,865,359	0	2.00
3.00	Buildings and Fixtures	101,883,063	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	3,686,594	0	5.00
6.00	Movable Equipment	82,949,961	0	6.00
7.00	HIT designated Assets	1,011,289	0	7.00
8.00	Subtotal (sum of lines 1-7)	202,011,658	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	202,011,658	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part II | Date/Time Prepared: 5/16/2018 8:40 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	6,108,655	0	1,935,039	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,023,550	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	12,132,205	0	1,935,039	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	8,043,694	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	6,023,550	2.00
3.00	Total (sum of lines 1-2)	0	14,067,244	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 5/16/2018 8:40 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	114,363,815	0	114,363,815	0.566125	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	87,647,841	0	87,647,841	0.433875	0	2.00
3.00	Total (sum of lines 1-2)	202,011,656	0	202,011,656	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	6,481,371	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	8,281,042	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	14,762,413	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	1,935,039	0	0	0	8,416,410	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	-1,398,096	0	0	0	6,882,946	2.00
3.00	Total (sum of lines 1-2)	536,943	0	0	0	15,299,356	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/16/2018 8:40 am

	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)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-18,540,840			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-15,635,326			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	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		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	BAD DEBT	A	-395,571	SKILLED NURSING FACILITY	44.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/16/2018 8:40 am

	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	
33.01	GIFT	A	-11,756	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	GIFT	A	-37,438	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	GIFT	A	-1,629	NURSING ADMINISTRATION	13.00	0	33.03
33.04	GIFT	A	-209	PHARMACY	15.00	0	33.04
33.05	GIFT	A	-26,179	ADULTS & PEDIATRICS	30.00	0	33.05
33.06	GIFT	A	-286	INTENSIVE CARE UNIT	31.00	0	33.06
33.07	GIFT	A	-171	SUBPROVIDER - IPF	40.00	0	33.07
33.08	GIFT	A	-2,107	SKILLED NURSING FACILITY	44.00	0	33.08
33.09	GIFT	A	-75	OPERATING ROOM	50.00	0	33.09
33.10	GIFT	A	-20	RECOVERY ROOM	51.00	0	33.10
33.11	GIFT	A	-15	PERINATAL CLINIC	52.01	0	33.11
33.12	GIFT	A	-2,208	RADIOLOGY-DIAGNOSTIC	54.00	0	33.12
33.13	GIFT	A	-29	ELECTROENCEPHALOGRAPHY	70.00	0	33.13
33.14	GIFT	A	-10	ENDOSCOPY	76.00	0	33.14
33.15	GIFT	A	-193	EMERGENCY	91.00	0	33.15
33.16	GIFT	A	-502	CLINIC	90.00	0	33.16
33.17	PHONE	A	-40,711	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	PHONE	A	-300	OPERATION OF PLANT	7.00	0	33.18
33.19	PHONE	A	-592	DIETARY	10.00	0	33.19
33.20	PHONE	A	-90	NURSING ADMINISTRATION	13.00	0	33.20
33.21	PHONE	A	-1,897	SKILLED NURSING FACILITY	44.00	0	33.21
33.22	PHONE	A	-5,511	CLINIC	90.00	0	33.22
33.23	PHONE	A	-345	EMERGENCY	91.00	0	33.23
33.24	ENTERTAINMENT	A	-34,917	ADMINISTRATIVE & GENERAL	5.00	0	33.24
33.25	ENTERTAINMENT	A	-169	NURSING ADMINISTRATION	13.00	0	33.25
33.26	ENTERTAINMENT	A	-55	SKILLED NURSING FACILITY	44.00	0	33.26
33.27	ENTERTAINMENT	A	-227	RADIOLOGY-DIAGNOSTIC	54.00	0	33.27
33.28	NURSE PRACTIONER	A	-168,016	ADULTS & PEDIATRICS	30.00	0	33.28
33.29	NURSE PRACTIONER	A	-107,552	SUBPROVIDER - IPF	40.00	0	33.29
33.30	NON-MEDICAL TRANSPORT	A	-90	ADMINISTRATIVE & GENERAL	5.00	0	33.30
33.31	NON-MEDICAL TRANSPORT	A	-77,757	SOCIAL SERVICE	17.00	0	33.31
33.32	NON-MEDICAL TRANSPORT	A	-50,650	SUBPROVIDER - IPF	40.00	0	33.32
33.33	NON-MEDICAL TRANSPORT	A	-19	SKILLED NURSING FACILITY	44.00	0	33.33
33.34	NON-MEDICAL TRANSPORT	A	-133,190	CLINIC	90.00	0	33.34
33.35	MARKETING	A	-8,465	ADMINISTRATIVE & GENERAL	5.00	0	33.35
33.36	MARKETING	A	-23,430	SKILLED NURSING FACILITY	44.00	0	33.36
33.37	MARKETING	A	-239	OPERATING ROOM	50.00	0	33.37
33.38	MARKETING	A	-182	CLINIC	90.00	9	33.38
33.39	MARKETING	A	-39	EMERGENCY	91.00	0	33.39
33.40	FRA	A	-509,266	ADMINISTRATIVE & GENERAL	5.00	0	33.40
33.41	INTEREST INCOME	A	0	ADMINISTRATIVE & GENERAL	5.00	0	33.41
33.42	MISCELLANEOUS REVENUE	B	-1,287,313	ADMINISTRATIVE & GENERAL	5.00	0	33.42
33.43	MISCELLANEOUS REVENUE	B	-267,965	OPERATION OF PLANT	7.00	0	33.43
33.44	MISCELLANEOUS REVENUE	B	-1,790,242	DIETARY	10.00	0	33.44
33.45	MISCELLANEOUS REVENUE	B	-650	NURSING ADMINISTRATION	13.00	0	33.45
33.46	MISCELLANEOUS REVENUE	B	-9,782	PHARMACY	15.00	0	33.46
33.47	MISCELLANEOUS REVENUE	B	-2,668	MEDICAL RECORDS & LIBRARY	16.00	0	33.47
33.48	MISCELLANEOUS REVENUE	B	-12,500	PHARMACY RESIDENCY PROGRAM	23.00	0	33.48
33.49	MISCELLANEOUS REVENUE	B	-6,650	ADULTS & PEDIATRICS	30.00	0	33.49
33.50	MISCELLANEOUS REVENUE	B	-1,660	SUBPROVIDER - IPF	40.00	0	33.50
33.51	MISCELLANEOUS REVENUE	B	-10,145	OPERATING ROOM	50.00	0	33.51
33.52	MISCELLANEOUS REVENUE	B	-5,275	PERINATAL CLINIC	52.01	0	33.52
33.53	MISCELLANEOUS REVENUE	B	-18,869	ANESTHESIOLOGY	53.00	0	33.53
33.54	MISCELLANEOUS REVENUE	B	-487,841	RADIOLOGY-DIAGNOSTIC	54.00	0	33.54
33.55	MISCELLANEOUS REVENUE	B	-26,074	RADIOLOGY-THERAPEUTIC	55.00	0	33.55
33.56	MISCELLANEOUS REVENUE	B	-313	RADIOISOTOPE	56.00	0	33.56
33.57	MISCELLANEOUS REVENUE	B	-58,552	CT SCAN	57.00	0	33.57
33.58	MISCELLANEOUS REVENUE	B	-25,824	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	33.58
33.59	MISCELLANEOUS REVENUE	B	-9,077	CARDIAC CATHETERIZATION	59.00	0	33.59
33.60	MISCELLANEOUS REVENUE	B	-1,929,583	LABORATORY	60.00	0	33.60
33.61	MISCELLANEOUS REVENUE	B	-81,551	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	0	33.61
33.62	MISCELLANEOUS REVENUE	B	-77,829	INTRAVENOUS THERAPY	64.00	0	33.62
33.63	MISCELLANEOUS REVENUE	B	-463	RESPIRATORY THERAPY	65.00	0	33.63
33.64	MISCELLANEOUS REVENUE	B	-80	PHYSICAL THERAPY	66.00	0	33.64
33.65	MISCELLANEOUS REVENUE	B	-74,817	CLINICAL NUTRITION	66.01	0	33.65
33.66	MISCELLANEOUS REVENUE	B	-4,736	ELECTROCARDIOLOGY	69.00	0	33.66
33.67	MISCELLANEOUS REVENUE	B	-422	ELECTROENCEPHALOGRAPHY	70.00	0	33.67

ADJUSTMENTS TO EXPENSES | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/16/2018 8:40 am

	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	
33.68	MISCELLANEOUS REVENUE	B	-1,707	RENAL DIALYSIS	74.00	0	33.68
33.69	MISCELLANEOUS REVENUE	B	-1,156	ENDOSCOPY	76.00	0	33.69
33.70	MISCELLANEOUS REVENUE	B	-957,110	CLINIC	90.00	0	33.70
33.71	MISCELLANEOUS REVENUE	B	-7,909	EMERGENCY	91.00	0	33.71
33.72	LOBBYING	A	-48,439	ADMINISTRATIVE & GENERAL	5.00	0	33.72
33.73	MISC MD COMPENSATION	A	-899,539	CLINIC	90.00	0	33.73
33.74	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.74
33.75	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.75
33.76	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.76
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-43,925,014				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: 26-0104	Period: From 01/01/2017 To 12/31/2017	Worksheet A-8-1 Date/Time Prepared: 5/16/2018 8:40 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	425,497	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	2,257,492	0	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE - INTEREST	0	1,398,096	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	17,263,374	20,770,790	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	26,455,291	38,936,904	4.01
4.02	7.00	OPERATION OF PLANT	HOME OFFICE	0	1,285,000	4.02
4.03	71.00	MEDICAL SUPPLIES CHARGED TO	HOME OFFICE	-232,733	0	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	NETWORK--CORP 130	12,652,770	12,064,234	4.04
4.05	13.00	NURSING ADMINISTRATION	NETWORK--CORP 130	217,265	217,265	4.05
4.06	30.00	ADULTS & PEDIATRICS	NETWORK--CORP 130	323,185	322,823	4.06
4.07	40.00	SUBPROVIDER - IPF	NETWORK--CORP 130	2,177,098	2,179,558	4.07
4.08	55.00	RADIOLOGY-THERAPEUTIC	NETWORK--CORP 130	93,273	93,168	4.08
4.09	70.00	ELECTROENCEPHALOGRAPHY	NETWORK--CORP 130	99	99	4.09
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			61,632,611	77,267,937	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		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	G	SSM HEALTH CARE	100.00	FRAN SISTERS SM	100.00	6.00
7.00	G	SSM HEALTH CARE	100.00	FRAN SISTERS SM	100.00	7.00
8.00	G	SSM HEALTH CARE	100.00	FRAN SISTERS SM	100.00	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:	CHURCH				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: 26-0104	Period: From 01/01/2017 To 12/31/2017	Worksheet A-8-1 Date/Time Prepared: 5/16/2018 8:40 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	425,497	9		1.00
2.00	2,257,492	9		2.00
3.00	-1,398,096	11		3.00
4.00	-3,507,416	0		4.00
4.01	-12,481,613	0		4.01
4.02	-1,285,000	0		4.02
4.03	-232,733	0		4.03
4.04	588,536	0		4.04
4.05	0	0		4.05
4.06	362	0		4.06
4.07	-2,460	0		4.07
4.08	105	0		4.08
4.09	0	0		4.09
5.00	-15,635,326			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	ST. LOUIS NETWO		7.00
8.00	SSM HOSPITALS		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: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 5/16/2018 8:40 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	1,296,205	899,839	396,366	179,000	2,322	1.00
2.00	15.00	PHARMACY	2,027	2,027	0	179,000	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	7,547,277	7,320,038	227,239	179,000	2,009	3.00
4.00	31.00	INTENSIVE CARE UNIT	2,618,110	2,618,110	0	179,000	0	4.00
5.00	40.00	SUBPROVIDER - IPF	934,656	934,656	0	181,300	112	5.00
6.00	50.00	OPERATING ROOM	78,294	0	78,294	246,400	502	6.00
7.00	52.01	PERINATAL CLINIC	727,750	727,750	0	237,100	0	7.00
8.00	53.00	ANESTHESIOLOGY	2,840,950	2,753,233	87,717	239,400	467	8.00
9.00	60.00	LABORATORY	285,289	251,945	33,344	260,300	299	9.00
10.00	65.00	RESPIRATORY THERAPY	28,275	0	28,275	179,000	189	10.00
11.00	69.00	ELECTROCARDIOLOGY	323,894	323,894	0	179,000	0	11.00
12.00	69.01	CARDIAC REHABILITATION	1,726	0	1,726	179,000	8	12.00
13.00	74.00	RENAL DIALYSIS	16	16	0	179,000	0	13.00
14.00	90.00	CLINIC	1,009,219	947,267	61,952	179,000	376	14.00
15.00	91.00	EMERGENCY	1,415,741	1,415,741	0	179,000	0	15.00
200.00			19,109,429	18,194,516	914,913		6,284	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	5.00	ADMINISTRATIVE & GENERAL	199,826	9,991	0	0	0	1.00
2.00	15.00	PHARMACY	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	172,890	8,645	0	0	0	3.00
4.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	4.00
5.00	40.00	SUBPROVIDER - IPF	9,762	488	0	0	0	5.00
6.00	50.00	OPERATING ROOM	59,468	2,973	0	0	0	6.00
7.00	52.01	PERINATAL CLINIC	0	0	0	0	0	7.00
8.00	53.00	ANESTHESIOLOGY	53,750	2,688	0	0	0	8.00
9.00	60.00	LABORATORY	37,418	1,871	0	0	0	9.00
10.00	65.00	RESPIRATORY THERAPY	16,265	813	0	0	0	10.00
11.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	11.00
12.00	69.01	CARDIAC REHABILITATION	688	34	0	0	0	12.00
13.00	74.00	RENAL DIALYSIS	0	0	0	0	0	13.00
14.00	90.00	CLINIC	32,358	1,618	0	0	0	14.00
15.00	91.00	EMERGENCY	0	0	0	0	0	15.00
200.00			582,425	29,121	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	5.00	ADMINISTRATIVE & GENERAL	0	199,826	196,540	1,096,379		1.00
2.00	15.00	PHARMACY	0	0	0	2,027		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	172,890	54,349	7,374,387		3.00
4.00	31.00	INTENSIVE CARE UNIT	0	0	0	2,618,110		4.00
5.00	40.00	SUBPROVIDER - IPF	0	9,762	0	934,656		5.00
6.00	50.00	OPERATING ROOM	0	59,468	18,826	18,826		6.00
7.00	52.01	PERINATAL CLINIC	0	0	0	727,750		7.00
8.00	53.00	ANESTHESIOLOGY	0	53,750	33,967	2,787,200		8.00
9.00	60.00	LABORATORY	0	37,418	0	251,945		9.00
10.00	65.00	RESPIRATORY THERAPY	0	16,265	12,010	12,010		10.00
11.00	69.00	ELECTROCARDIOLOGY	0	0	0	323,894		11.00
12.00	69.01	CARDIAC REHABILITATION	0	688	1,038	1,038		12.00
13.00	74.00	RENAL DIALYSIS	0	0	0	16		13.00
14.00	90.00	CLINIC	0	32,358	29,594	976,861		14.00
15.00	91.00	EMERGENCY	0	0	0	1,415,741		15.00
200.00			0	582,425	346,324	18,540,840		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/16/2018 8:40 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	8,416,410	8,416,410				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	6,882,946		6,882,946			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	30,948,070	33,596	0	30,981,666		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	78,251,073	1,354,629	354,426	2,883,122	82,843,250	5.00
7.00	00700	OPERATION OF PLANT	9,714,369	735,931	488,157	434,770	11,373,227	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,010,763	25,309	0	40,515	1,076,587	8.00
9.00	00900	HOUSEKEEPING	4,342,107	19,665	16,063	693,165	5,071,000	9.00
10.00	01000	DIETARY	5,007,079	200,068	106,630	651,784	5,965,561	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,461,363	76,087	408,778	737,462	4,683,690	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,754,221	221,894	167,086	150,041	3,293,242	14.00
15.00	01500	PHARMACY	6,286,096	32,803	12,844	1,281,164	7,612,907	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	948,735	50,664	2,242	112,269	1,113,910	16.00
17.00	01700	SOCIAL SERVICE	593,190	13,792	0	110,510	717,492	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	906,050	0	0	219,493	1,125,543	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	80,353	13,838	0	0	94,191	22.00
23.00	02300	PHARMACY RESIDENCY PROGRAM	135,510	6,184	0	31,861	173,555	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,442,150	2,093,352	432,651	9,289,756	46,257,909	30.00
31.00	03100	INTENSIVE CARE UNIT	7,953,852	245,031	203,014	1,831,128	10,233,025	31.00
40.00	04000	SUBPROVIDER - IPF	1,286,831	369,678	23,093	469,551	2,149,153	40.00
43.00	04300	NURSERY	717,627	67,525	0	156,676	941,828	43.00
44.00	04400	SKILLED NURSING FACILITY	4,051,389	0	134,664	0	4,186,053	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,669,700	697,037	709,829	2,115,288	17,191,854	50.00
51.00	05100	RECOVERY ROOM	1,062,759	0	2,730	253,321	1,318,810	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,329,669	27,619	0	484,033	2,841,321	52.00
52.01	05201	PERINATAL CLINIC	649,091	175,610	26,248	133,609	984,558	52.01
53.00	05300	ANESTHESIOLOGY	678,690	10,287	35,139	17,692	741,808	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,539,763	278,971	447,695	921,898	9,188,327	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,847,257	176,702	1,294,674	505,925	4,824,558	55.00
56.00	05600	RADIOISOTOPE	998,410	17,493	85,795	71,203	1,172,901	56.00
57.00	05700	CT SCAN	1,196,616	0	169,371	196,876	1,562,863	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	459,606	31,987	932,223	96,999	1,520,815	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,370,139	89,213	152,127	321,414	2,932,893	59.00
60.00	06000	LABORATORY	3,381,487	259,811	34,658	534,978	4,210,934	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,972,707	9,551	3,852	119,743	3,105,853	62.00
64.00	06400	INTRAVENOUS THERAPY	2,212,402	0	14,513	436,893	2,663,808	64.00
65.00	06500	RESPIRATORY THERAPY	3,442,711	93,190	134,520	590,329	4,260,750	65.00
66.00	06600	PHYSICAL THERAPY	2,214,860	91,810	0	0	2,306,670	66.00
66.01	06601	CLINICAL NUTRITION	679,657	0	0	182,066	861,723	66.01
67.00	06700	OCCUPATIONAL THERAPY	1,005,129	49,020	0	0	1,054,149	67.00
68.00	06800	SPEECH PATHOLOGY	449,906	1,138	1,146	0	452,190	68.00
69.00	06900	ELECTROCARDIOLOGY	3,170,765	0	231,833	653,824	4,056,422	69.00
69.01	06901	CARDIAC REHABILITATION	661,671	120,751	10,033	157,453	949,908	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	407,292	7,908	76,433	64,270	555,903	70.00
70.01	07001	ELECTROSHOCK THERAPY	91,404	0	1,562	21,497	114,463	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	23,475,170	0	0	0	23,475,170	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,523,052	0	0	0	20,523,052	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30,738,558	0	0	0	30,738,558	73.00
74.00	07400	RENAL DIALYSIS	1,584,806	17,033	2,027	4	1,603,870	74.00
76.00	03330	ENDOSCOPY	1,394,465	47,422	27,466	236,183	1,705,536	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	8,495,788	299,740	3,683	1,541,955	10,341,166	90.00
91.00	09100	EMERGENCY	9,386,418	318,946	125,559	2,181,600	12,012,523	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	358,280,132	8,381,285	6,872,764	30,932,320	358,185,479	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	102,694	19,367	2,873	12,492	137,426	190.00
191.00	19100	RESEARCH	92,193	0	0	22,334	114,527	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	11,873	0	0	11,873	192.00
194.00	07951	NON-REIMBURSABLE	67,349	3,885	7,309	14,520	93,063	194.00
194.01	07950	RETAIL PHARMACY	7,727,269	0	0	0	7,727,269	194.01
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)	366,269,637	8,416,410	6,882,946	30,981,666	366,269,637	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/16/2018 8:40 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	82,843,250					5.00
7.00	00700	OPERATION OF PLANT	3,324,303	14,697,530				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	314,678	59,117	1,450,382			8.00
9.00	00900	HOUSEKEEPING	1,482,213	45,935	0	6,599,148		9.00
10.00	01000	DIETARY	1,743,686	467,322	0	211,337	8,387,906	10.00
11.00	01100	CAFETERIA	0	0	0	0	5,754,371	11.00
13.00	01300	NURSING ADMINISTRATION	1,369,005	177,726	0	80,373	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	962,588	518,304	0	234,392	0	14.00
15.00	01500	PHARMACY	2,225,192	76,621	0	34,650	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	325,587	118,341	0	53,517	0	16.00
17.00	01700	SOCIAL SERVICE	209,717	32,216	0	14,569	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	328,987	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	27,531	32,324	0	14,618	0	22.00
23.00	02300	PHARMACY RESIDENCY PROGRAM	50,729	14,444	0	6,532	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,520,801	4,889,675	112,241	2,211,257	2,135,079	30.00
31.00	03100	INTENSIVE CARE UNIT	2,991,031	572,346	29,217	258,832	308,560	31.00
40.00	04000	SUBPROVIDER - IPF	628,180	863,499	0	390,500	114,786	40.00
43.00	04300	NURSERY	275,289	157,725	76,610	71,328	66,299	43.00
44.00	04400	SKILLED NURSING FACILITY	1,223,550	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,025,041	1,628,149	382,437	736,297	0	50.00
51.00	05100	RECOVERY ROOM	385,478	0	30,409	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	830,495	64,513	257,314	29,175	8,811	52.00
52.01	05201	PERINATAL CLINIC	287,778	410,192	15,579	185,501	0	52.01
53.00	05300	ANESTHESIOLOGY	216,825	24,028	3,464	10,866	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,685,674	651,625	187,517	294,684	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,410,180	412,742	10,043	186,654	0	55.00
56.00	05600	RADIOISOTOPE	342,830	40,861	0	18,478	0	56.00
57.00	05700	CT SCAN	456,812	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	444,522	74,715	7,903	33,788	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	857,261	208,385	7,713	94,238	0	59.00
60.00	06000	LABORATORY	1,230,822	606,871	39,441	274,445	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	907,816	22,310	0	10,089	0	62.00
64.00	06400	INTRAVENOUS THERAPY	778,610	0	3,856	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,245,383	217,674	0	98,438	0	65.00
66.00	06600	PHYSICAL THERAPY	674,221	214,452	3,161	96,981	0	66.00
66.01	06601	CLINICAL NUTRITION	251,875	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	308,119	114,501	0	51,781	0	67.00
68.00	06800	SPEECH PATHOLOGY	132,172	2,658	0	1,202	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,185,660	0	46,481	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	277,651	282,052	0	127,552	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	162,486	18,471	0	8,353	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	33,457	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,861,604	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,998,724	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,984,635	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	468,798	39,787	9,063	17,993	0	74.00
76.00	03330	ENDOSCOPY	498,515	110,770	43,469	50,093	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,022,640	700,137	0	316,622	0	90.00
91.00	09100	EMERGENCY	3,511,164	744,998	181,502	336,910	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	80,480,315	14,615,486	1,447,420	6,562,045	8,387,906	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	40,169	45,237	0	20,457	0	190.00
191.00	19100	RESEARCH	33,475	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,470	27,733	0	12,542	0	192.00
194.00	07951	NON-REIMBURSABLE	27,202	9,074	2,962	4,104	0	194.00
194.01	07950	RETAIL PHARMACY	2,258,619	0	0	0	0	194.01
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)	82,843,250	14,697,530	1,450,382	6,599,148	8,387,906	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/16/2018 8:40 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	5,754,371					11.00
13.00	01300	NURSING ADMINISTRATION	152,224	6,463,018				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	69,295	0	5,077,821			14.00
15.00	01500	PHARMACY	222,387	378	0	10,172,135		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	45,525	0	0	0	1,656,880	16.00
17.00	01700	SOCIAL SERVICE	26,913	29	999	77,271	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	3,884	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PHARMACY RESIDENCY PROGRAM	7,340	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,223,248	3,154,174	32,646	19,949	215,020	30.00
31.00	03100	INTENSIVE CARE UNIT	418,444	673,824	9,093	8,271	45,942	31.00
40.00	04000	SUBPROVIDER - IPF	64,750	395,202	412	4,391	8,933	40.00
43.00	04300	NURSERY	40,527	52,885	0	0	4,732	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	22,610	1,515,424	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	452,881	523,725	29,483	750,520	152,177	50.00
51.00	05100	RECOVERY ROOM	47,685	71,719	847	23	15,187	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	130,327	145,518	0	0	14,669	52.00
52.01	05201	PERINATAL CLINIC	30,533	19,715	30	0	7,902	52.01
53.00	05300	ANESTHESIOLOGY	8,299	14,264	3,045	130	40,515	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	253,002	110,222	17,106	106,123	93,340	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	79,811	12,702	137	145	46,586	55.00
56.00	05600	RADIOISOTOPE	13,734	0	65,830	2,653	9,738	56.00
57.00	05700	CT SCAN	47,656	115	19,166	30,864	92,369	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	20,856	11	8,025	0	30,103	58.00
59.00	05900	CARDIAC CATHETERIZATION	58,323	73,612	63,649	669,217	53,839	59.00
60.00	06000	LABORATORY	127,524	32	158,443	0	134,549	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	30,729	0	126,362	488	15,573	62.00
64.00	06400	INTRAVENOUS THERAPY	72,038	113,849	879	816	14,514	64.00
65.00	06500	RESPIRATORY THERAPY	147,130	0	31,023	39,036	34,500	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	9,079	66.00
66.01	06601	CLINICAL NUTRITION	52,362	0	0	0	320	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	4,197	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	2,890	68.00
69.00	06900	ELECTROCARDIOLOGY	190,199	240,900	4,643	2,958	78,806	69.00
69.01	06901	CARDIAC REHABILITATION	29,122	40,230	1	69	1,556	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	1,805	3,102	6	38	8,543	70.00
70.01	07001	ELECTROSHOCK THERAPY	5,171	8,888	0	0	904	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	2,352,717	0	42,532	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,023,532	0	45,091	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	286,698	73.00
74.00	07400	RENAL DIALYSIS	0	0	652	259	6,817	74.00
76.00	03330	ENDOSCOPY	52,262	83,767	3,369	3,552	19,806	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	139,174	27,686	89,209	6,853,032	30,163	90.00
91.00	09100	EMERGENCY	472,012	689,283	13,881	84,909	89,290	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,737,172	6,455,832	5,077,795	10,170,138	1,656,880	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,110	0	0	0	0	190.00
191.00	19100	RESEARCH	4,028	6,923	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	NON-REIMBURSABLE	6,061	263	26	1,997	0	194.00
194.01	07950	RETAIL PHARMACY	0	0	0	0	0	194.01
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)	5,754,371	6,463,018	5,077,821	10,172,135	1,656,880	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/16/2018 8:40 am

		Cost Center Description	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS	PHARMACY RESIDENCY PROGRAM	Subtotal	
			17.00	21.00	22.00	23.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	1,079,206					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	1,458,414				21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0		168,664			22.00
23.00	02300	PHARMACY RESIDENCY PROGRAM	0			252,600		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	874,944	926,959	107,202	84,200	76,765,304	30.00
31.00	03100	INTENSIVE CARE UNIT	126,445	0	0	42,100	15,717,130	31.00
40.00	04000	SUBPROVIDER - IPF	47,039	0	0	42,100	4,708,945	40.00
43.00	04300	NURSERY	27,168	0	0	0	1,714,391	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	6,947,637	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	459,771	53,172	0	27,385,507	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	1,870,158	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,610	0	0	0	4,325,753	52.00
52.01	05201	PERINATAL CLINIC	0	0	0	0	1,941,788	52.01
53.00	05300	ANESTHESIOLOGY	0	12,359	1,429	0	1,077,032	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	24,719	2,859	0	13,615,198	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	6,983,558	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	1,667,025	56.00
57.00	05700	CT SCAN	0	0	0	0	2,209,845	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	2,140,738	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	12,359	1,429	0	5,032,918	59.00
60.00	06000	LABORATORY	0	0	0	0	6,783,061	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	4,219,220	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	3,648,370	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	6,073,934	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	3,304,564	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	0	1,166,280	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	1,532,747	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	591,112	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	42,100	5,848,169	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	1,708,141	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	758,707	70.00
70.01	07001	ELECTROSHOCK THERAPY	0	0	0	0	162,883	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	32,732,023	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	28,590,399	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	40,009,891	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	2,147,239	74.00
76.00	03330	ENDOSCOPY	0	0	0	0	2,571,139	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	21,519,829	90.00
91.00	09100	EMERGENCY	0	22,247	2,573	42,100	18,203,392	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,079,206	1,458,414	168,664	252,600	355,674,027	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	250,399	190.00
191.00	19100	RESEARCH	0	0	0	0	158,953	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	55,618	192.00
194.00	07951	NON-REIMBURSABLE	0	0	0	0	144,752	194.00
194.01	07950	RETAIL PHARMACY	0	0	0	0	9,985,888	194.01
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,079,206	1,458,414	168,664	252,600	366,269,637	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/16/2018 8:40 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD				22.00
23.00	02300	PHARMACY RESIDENCY PROGRAM				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,034,161	75,731,143		30.00
31.00	03100	INTENSIVE CARE UNIT	0	15,717,130		31.00
40.00	04000	SUBPROVIDER - IPF	0	4,708,945		40.00
43.00	04300	NURSERY	0	1,714,391		43.00
44.00	04400	SKILLED NURSING FACILITY	0	6,947,637		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-512,943	26,872,564		50.00
51.00	05100	RECOVERY ROOM	0	1,870,158		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,325,753		52.00
52.01	05201	PERINATAL CLINIC	0	1,941,788		52.01
53.00	05300	ANESTHESIOLOGY	-13,788	1,063,244		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-27,578	13,587,620		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	6,983,558		55.00
56.00	05600	RADIOISOTOPE	0	1,667,025		56.00
57.00	05700	CT SCAN	0	2,209,845		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,140,738		58.00
59.00	05900	CARDIAC CATHETERIZATION	-13,788	5,019,130		59.00
60.00	06000	LABORATORY	0	6,783,061		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	4,219,220		62.00
64.00	06400	INTRAVENOUS THERAPY	0	3,648,370		64.00
65.00	06500	RESPIRATORY THERAPY	0	6,073,934		65.00
66.00	06600	PHYSICAL THERAPY	0	3,304,564		66.00
66.01	06601	CLINICAL NUTRITION	0	1,166,280		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	1,532,747		67.00
68.00	06800	SPEECH PATHOLOGY	0	591,112		68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,848,169		69.00
69.01	06901	CARDIAC REHABILITATION	0	1,708,141		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	758,707		70.00
70.01	07001	ELECTROSHOCK THERAPY	0	162,883		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	32,732,023		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	28,590,399		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	40,009,891		73.00
74.00	07400	RENAL DIALYSIS	0	2,147,239		74.00
76.00	03330	ENDOSCOPY	0	2,571,139		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	21,519,829		90.00
91.00	09100	EMERGENCY	-24,820	18,178,572		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,627,078	354,046,949		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	250,399		190.00
191.00	19100	RESEARCH	0	158,953		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	55,618		192.00
194.00	07951	NON-REIMBURSABLE	0	144,752		194.00
194.01	07950	RETAIL PHARMACY	0	9,985,888		194.01
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	-1,627,078	364,642,559		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/16/2018 8:40 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	33,596	0	33,596	33,596	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,653,573	1,354,629	354,426	5,362,628	3,130	5.00
7.00	00700	OPERATION OF PLANT	0	735,931	488,157	1,224,088	472	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	25,309	0	25,309	44	8.00
9.00	00900	HOUSEKEEPING	0	19,665	16,063	35,728	753	9.00
10.00	01000	DIETARY	15,893	200,068	106,630	322,591	708	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	76,087	408,778	484,865	801	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	120,805	221,894	167,086	509,785	163	14.00
15.00	01500	PHARMACY	522,298	32,803	12,844	567,945	1,391	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	50,664	2,242	52,906	122	16.00
17.00	01700	SOCIAL SERVICE	0	13,792	0	13,792	120	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	27,984	0	0	27,984	238	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	13,838	0	13,838	0	22.00
23.00	02300	PHARMACY RESIDENCY PROGRAM	0	6,184	0	6,184	35	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,568	2,093,352	432,651	2,527,571	10,046	30.00
31.00	03100	INTENSIVE CARE UNIT	0	245,031	203,014	448,045	1,988	31.00
40.00	04000	SUBPROVIDER - IPF	0	369,678	23,093	392,771	510	40.00
43.00	04300	NURSERY	0	67,525	0	67,525	170	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	134,664	134,664	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,508,961	697,037	709,829	2,915,827	2,296	50.00
51.00	05100	RECOVERY ROOM	0	0	2,730	2,730	275	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	27,619	0	27,619	525	52.00
52.01	05201	PERINATAL CLINIC	127,209	175,610	26,248	329,067	145	52.01
53.00	05300	ANESTHESIOLOGY	105,789	10,287	35,139	151,215	19	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	225,406	278,971	447,695	952,072	1,001	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	667,423	176,702	1,294,674	2,138,799	549	55.00
56.00	05600	RADIOISOTOPE	0	17,493	85,795	103,288	77	56.00
57.00	05700	CT SCAN	36,000	0	169,371	205,371	214	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	31,987	932,223	964,210	105	58.00
59.00	05900	CARDIAC CATHETERIZATION	77,513	89,213	152,127	318,853	349	59.00
60.00	06000	LABORATORY	107,365	259,811	34,658	401,834	581	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	9,551	3,852	13,403	130	62.00
64.00	06400	INTRAVENOUS THERAPY	316,229	0	14,513	330,742	474	64.00
65.00	06500	RESPIRATORY THERAPY	124,267	93,190	134,520	351,977	641	65.00
66.00	06600	PHYSICAL THERAPY	0	91,810	0	91,810	0	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	0	198	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	49,020	0	49,020	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,138	1,146	2,284	0	68.00
69.00	06900	ELECTROCARDIOLOGY	196,815	0	231,833	428,648	710	69.00
69.01	06901	CARDIAC REHABILITATION	0	120,751	10,033	130,784	171	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	67,100	7,908	76,433	151,441	70	70.00
70.01	07001	ELECTROSHOCK THERAPY	0	0	1,562	1,562	23	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	17,033	2,027	19,060	0	74.00
76.00	03330	ENDOSCOPY	348,980	47,422	27,466	423,868	256	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,096,114	299,740	3,683	1,399,537	1,674	90.00
91.00	09100	EMERGENCY	132,111	318,946	125,559	576,616	2,368	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,479,403	8,381,285	6,872,764	24,733,452	33,542	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,367	2,873	22,240	14	190.00
191.00	19100	RESEARCH	0	0	0	0	24	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	11,873	0	11,873	0	192.00
194.00	07951	NON-REIMBURSABLE	0	3,885	7,309	11,194	16	194.00
194.01	07950	RETAIL PHARMACY	0	0	0	0	0	194.01
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)	9,479,403	8,416,410	6,882,946	24,778,759	33,596	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/16/2018 8:40 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,365,758					5.00
7.00	00700	OPERATION OF PLANT	215,318	1,439,878				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	20,382	5,791	51,526			8.00
9.00	00900	HOUSEKEEPING	96,004	4,500	0	136,985		9.00
10.00	01000	DIETARY	112,940	45,782	0	4,387	486,408	10.00
11.00	01100	CAFETERIA	0	0	0	0	333,692	11.00
13.00	01300	NURSING ADMINISTRATION	88,672	17,411	0	1,668	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	62,348	50,777	0	4,866	0	14.00
15.00	01500	PHARMACY	144,128	7,506	0	719	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	21,089	11,594	0	1,111	0	16.00
17.00	01700	SOCIAL SERVICE	13,584	3,156	0	302	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21,309	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	1,783	3,167	0	303	0	22.00
23.00	02300	PHARMACY RESIDENCY PROGRAM	3,286	1,415	0	136	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	875,682	479,029	3,987	45,901	123,811	30.00
31.00	03100	INTENSIVE CARE UNIT	193,732	56,071	1,038	5,373	17,893	31.00
40.00	04000	SUBPROVIDER - IPF	40,688	84,595	0	8,106	6,656	40.00
43.00	04300	NURSERY	17,831	15,452	2,722	1,481	3,845	43.00
44.00	04400	SKILLED NURSING FACILITY	79,250	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	325,476	159,505	13,588	15,284	0	50.00
51.00	05100	RECOVERY ROOM	24,968	0	1,080	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	53,792	6,320	9,141	606	511	52.00
52.01	05201	PERINATAL CLINIC	18,640	40,185	553	3,851	0	52.01
53.00	05300	ANESTHESIOLOGY	14,044	2,354	123	226	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	173,953	63,838	6,662	6,117	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	91,339	40,435	357	3,875	0	55.00
56.00	05600	RADIOISOTOPE	22,205	4,003	0	384	0	56.00
57.00	05700	CT SCAN	29,588	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	28,792	7,320	281	701	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	55,526	20,415	274	1,956	0	59.00
60.00	06000	LABORATORY	79,721	59,454	1,401	5,697	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	58,800	2,186	0	209	0	62.00
64.00	06400	INTRAVENOUS THERAPY	50,431	0	137	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	80,665	21,325	0	2,043	0	65.00
66.00	06600	PHYSICAL THERAPY	43,670	21,009	112	2,013	0	66.00
66.01	06601	CLINICAL NUTRITION	16,314	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	19,957	11,217	0	1,075	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,561	260	0	25	0	68.00
69.00	06900	ELECTROCARDIOLOGY	76,796	0	1,651	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	17,984	27,632	0	2,648	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	10,524	1,810	0	173	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	2,167	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	444,432	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	388,542	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	581,942	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	30,364	3,898	322	373	0	74.00
76.00	03330	ENDOSCOPY	32,289	10,852	1,544	1,040	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	195,779	68,591	0	6,572	0	90.00
91.00	09100	EMERGENCY	227,421	72,985	6,448	6,994	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,212,708	1,431,840	51,421	136,215	486,408	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,602	4,432	0	425	0	190.00
191.00	19100	RESEARCH	2,168	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	225	2,717	0	260	0	192.00
194.00	07951	NON-REIMBURSABLE	1,762	889	105	85	0	194.00
194.01	07950	RETAIL PHARMACY	146,293	0	0	0	0	194.01
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)	5,365,758	1,439,878	51,526	136,985	486,408	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/16/2018 8:40 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	333,692					11.00
13.00	01300	NURSING ADMINISTRATION	8,827	602,244				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,018	0	631,957			14.00
15.00	01500	PHARMACY	12,896	35	0	734,620		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,640	0	0	0	89,462	16.00
17.00	01700	SOCIAL SERVICE	1,561	3	124	5,580	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	225	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PHARMACY RESIDENCY PROGRAM	426	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	128,925	293,915	4,063	1,441	11,618	30.00
31.00	03100	INTENSIVE CARE UNIT	24,265	62,789	1,132	597	2,482	31.00
40.00	04000	SUBPROVIDER - IPF	3,755	36,826	51	317	483	40.00
43.00	04300	NURSERY	2,350	4,928	0	0	256	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	2,814	109,442	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,262	48,802	3,669	54,202	8,222	50.00
51.00	05100	RECOVERY ROOM	2,765	6,683	105	2	821	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,558	13,560	0	0	793	52.00
52.01	05201	PERINATAL CLINIC	1,771	1,837	4	0	427	52.01
53.00	05300	ANESTHESIOLOGY	481	1,329	379	9	2,189	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,671	10,271	2,129	7,664	5,043	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,628	1,184	17	10	2,517	55.00
56.00	05600	RADIOISOTOPE	796	0	8,193	192	526	56.00
57.00	05700	CT SCAN	2,764	11	2,385	2,229	4,991	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,209	1	999	0	1,626	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,382	6,859	7,921	48,330	2,909	59.00
60.00	06000	LABORATORY	7,395	3	19,719	0	7,270	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,782	0	15,726	35	841	62.00
64.00	06400	INTRAVENOUS THERAPY	4,177	10,609	109	59	784	64.00
65.00	06500	RESPIRATORY THERAPY	8,532	0	3,861	2,819	1,864	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	491	66.00
66.01	06601	CLINICAL NUTRITION	3,036	0	0	0	17	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	227	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	156	68.00
69.00	06900	ELECTROCARDIOLOGY	11,030	22,448	578	214	4,258	69.00
69.01	06901	CARDIAC REHABILITATION	1,689	3,749	0	5	84	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	105	289	1	3	462	70.00
70.01	07001	ELECTROSHOCK THERAPY	300	828	0	0	49	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	292,807	0	2,298	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	251,838	0	2,436	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	15,430	73.00
74.00	07400	RENAL DIALYSIS	0	0	81	19	368	74.00
76.00	03330	ENDOSCOPY	3,031	7,806	419	257	1,070	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	8,071	2,580	11,102	494,918	1,630	90.00
91.00	09100	EMERGENCY	27,372	64,230	1,728	6,132	4,824	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	332,695	601,575	631,954	734,476	89,462	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	412	0	0	0	0	190.00
191.00	19100	RESEARCH	234	645	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	NON-REIMBURSABLE	351	24	3	144	0	194.00
194.01	07950	RETAIL PHARMACY	0	0	0	0	0	194.01
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)	333,692	602,244	631,957	734,620	89,462	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/16/2018 8:40 am

		Cost Center Description	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS	PHARMACY RESIDENCY PROGRAM	Subtotal	
			17.00	21.00	22.00	23.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	38,222					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	49,756				21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0		19,091			22.00
23.00	02300	PHARMACY RESIDENCY PROGRAM	0			11,482		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,988				4,536,977	30.00
31.00	03100	INTENSIVE CARE UNIT	4,478				819,883	31.00
40.00	04000	SUBPROVIDER - IPF	1,666				576,424	40.00
43.00	04300	NURSERY	962				117,522	43.00
44.00	04400	SKILLED NURSING FACILITY	0				326,170	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0				3,573,133	50.00
51.00	05100	RECOVERY ROOM	0				39,429	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	128				120,553	52.00
52.01	05201	PERINATAL CLINIC	0				396,480	52.01
53.00	05300	ANESTHESIOLOGY	0				172,368	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0				1,243,421	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0				2,283,710	55.00
56.00	05600	RADIOISOTOPE	0				139,664	56.00
57.00	05700	CT SCAN	0				247,553	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0				1,005,244	58.00
59.00	05900	CARDIAC CATHETERIZATION	0				466,774	59.00
60.00	06000	LABORATORY	0				583,075	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0				93,112	62.00
64.00	06400	INTRAVENOUS THERAPY	0				397,522	64.00
65.00	06500	RESPIRATORY THERAPY	0				473,727	65.00
66.00	06600	PHYSICAL THERAPY	0				159,105	66.00
66.01	06601	CLINICAL NUTRITION	0				19,565	66.01
67.00	06700	OCCUPATIONAL THERAPY	0				81,496	67.00
68.00	06800	SPEECH PATHOLOGY	0				11,286	68.00
69.00	06900	ELECTROCARDIOLOGY	0				546,333	69.00
69.01	06901	CARDIAC REHABILITATION	0				184,746	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0				164,878	70.00
70.01	07001	ELECTROSHOCK THERAPY	0				4,929	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0				739,537	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0				642,816	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0				597,372	73.00
74.00	07400	RENAL DIALYSIS	0				54,485	74.00
76.00	03330	ENDOSCOPY	0				482,432	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0				2,190,454	90.00
91.00	09100	EMERGENCY	0				997,118	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	38,222	0	0	0	24,489,293	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0				30,125	190.00
191.00	19100	RESEARCH	0				3,071	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0				15,075	192.00
194.00	07951	NON-REIMBURSABLE	0				14,573	194.00
194.01	07950	RETAIL PHARMACY	0				146,293	194.01
200.00		Cross Foot Adjustments		49,756	19,091	11,482	80,329	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	38,222	49,756	19,091	11,482	24,778,759	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/16/2018 8:40 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD				22.00
23.00	02300	PHARMACY RESIDENCY PROGRAM				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	4,536,977		30.00
31.00	03100	INTENSIVE CARE UNIT	0	819,883		31.00
40.00	04000	SUBPROVIDER - IPF	0	576,424		40.00
43.00	04300	NURSERY	0	117,522		43.00
44.00	04400	SKILLED NURSING FACILITY	0	326,170		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	3,573,133		50.00
51.00	05100	RECOVERY ROOM	0	39,429		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	120,553		52.00
52.01	05201	PERINATAL CLINIC	0	396,480		52.01
53.00	05300	ANESTHESIOLOGY	0	172,368		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,243,421		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,283,710		55.00
56.00	05600	RADIOISOTOPE	0	139,664		56.00
57.00	05700	CT SCAN	0	247,553		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,005,244		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	466,774		59.00
60.00	06000	LABORATORY	0	583,075		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	93,112		62.00
64.00	06400	INTRAVENOUS THERAPY	0	397,522		64.00
65.00	06500	RESPIRATORY THERAPY	0	473,727		65.00
66.00	06600	PHYSICAL THERAPY	0	159,105		66.00
66.01	06601	CLINICAL NUTRITION	0	19,565		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	81,496		67.00
68.00	06800	SPEECH PATHOLOGY	0	11,286		68.00
69.00	06900	ELECTROCARDIOLOGY	0	546,333		69.00
69.01	06901	CARDIAC REHABILITATION	0	184,746		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	164,878		70.00
70.01	07001	ELECTROSHOCK THERAPY	0	4,929		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	739,537		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	642,816		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	597,372		73.00
74.00	07400	RENAL DIALYSIS	0	54,485		74.00
76.00	03330	ENDOSCOPY	0	482,432		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	2,190,454		90.00
91.00	09100	EMERGENCY	0	997,118		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	24,489,293		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	30,125		190.00
191.00	19100	RESEARCH	0	3,071		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	15,075		192.00
194.00	07951	NON-REIMBURSABLE	0	14,573		194.00
194.01	07950	RETAIL PHARMACY	0	146,293		194.01
200.00		Cross Foot Adjustments	0	80,329		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	24,778,759		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/16/2018 8:40 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	732,273					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		6,023,551				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,923	0	127,889,462			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	117,860	310,173	11,901,284	-82,843,250	283,426,387	5.00
7.00	00700	OPERATION OF PLANT	64,030	427,207	1,794,693	0	11,373,227	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,202	0	167,244	0	1,076,587	8.00
9.00	00900	HOUSEKEEPING	1,711	14,057	2,861,325	0	5,071,000	9.00
10.00	01000	DIETARY	17,407	93,316	2,690,508	0	5,965,561	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	6,620	357,739	3,044,182	0	4,683,690	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	19,306	146,224	619,355	0	3,293,242	14.00
15.00	01500	PHARMACY	2,854	11,240	5,288,537	0	7,612,907	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,408	1,962	463,436	0	1,113,910	16.00
17.00	01700	SOCIAL SERVICE	1,200	0	456,177	0	717,492	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	906,050	0	1,125,543	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	1,204	0	0	0	94,191	22.00
23.00	02300	PHARMACY RESIDENCY PROGRAM	538	0	131,519	0	173,555	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	182,133	378,631	38,347,083	0	46,257,909	30.00
31.00	03100	INTENSIVE CARE UNIT	21,319	177,666	7,558,744	0	10,233,025	31.00
40.00	04000	SUBPROVIDER - IPF	32,164	20,210	1,938,265	0	2,149,153	40.00
43.00	04300	NURSERY	5,875	0	646,747	0	941,828	43.00
44.00	04400	SKILLED NURSING FACILITY	0	117,850	0	0	4,186,053	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	60,646	621,201	8,731,732	0	17,191,854	50.00
51.00	05100	RECOVERY ROOM	0	2,389	1,045,689	0	1,318,810	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,403	0	1,998,046	0	2,841,321	52.00
52.01	05201	PERINATAL CLINIC	15,279	22,971	551,527	0	984,558	52.01
53.00	05300	ANESTHESIOLOGY	895	30,752	73,031	0	741,808	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,272	391,797	3,805,516	0	9,188,327	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	15,374	1,133,019	2,088,414	0	4,824,558	55.00
56.00	05600	RADIOISOTOPE	1,522	75,083	293,918	0	1,172,901	56.00
57.00	05700	CT SCAN	0	148,224	812,689	0	1,562,863	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,783	815,827	400,402	0	1,520,815	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,762	133,133	1,326,770	0	2,932,893	59.00
60.00	06000	LABORATORY	22,605	30,331	2,208,344	0	4,210,934	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	831	3,371	494,290	0	3,105,853	62.00
64.00	06400	INTRAVENOUS THERAPY	0	12,701	1,803,459	0	2,663,808	64.00
65.00	06500	RESPIRATORY THERAPY	8,108	117,724	2,436,828	0	4,260,750	65.00
66.00	06600	PHYSICAL THERAPY	7,988	0	0	0	2,306,670	66.00
66.01	06601	CLINICAL NUTRITION	0	0	751,555	0	861,723	66.01
67.00	06700	OCCUPATIONAL THERAPY	4,265	0	0	0	1,054,149	67.00
68.00	06800	SPEECH PATHOLOGY	99	1,003	0	0	452,190	68.00
69.00	06900	ELECTROCARDIOLOGY	0	202,887	2,698,932	0	4,056,422	69.00
69.01	06901	CARDIAC REHABILITATION	10,506	8,780	649,954	0	949,908	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	688	66,890	265,302	0	555,903	70.00
70.01	07001	ELECTROSHOCK THERAPY	0	1,367	88,737	0	114,463	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	23,475,170	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	20,523,052	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	30,738,558	73.00
74.00	07400	RENAL DIALYSIS	1,482	1,774	15	0	1,603,870	74.00
76.00	03330	ENDOSCOPY	4,126	24,037	974,944	0	1,705,536	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	26,079	3,223	6,365,061	0	10,341,166	90.00
91.00	09100	EMERGENCY	27,750	109,882	9,005,460	0	12,012,523	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	729,217	6,014,641	127,685,764	-82,843,250	275,342,229	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,685	2,514	51,567	0	137,426	190.00
191.00	19100	RESEARCH	0	0	92,193	0	114,527	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,033	0	0	0	11,873	192.00
194.00	07951	NON-REIMBURSABLE	338	6,396	59,938	0	93,063	194.00
194.01	07950	RETAIL PHARMACY	0	0	0	0	7,727,269	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/16/2018 8:40 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	8,416,410	6,882,946	30,981,666		82,843,250	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.493541	1.142672	0.242253		0.292292	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			33,596		5,365,758	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000263		0.018932	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: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/16/2018 8:40 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (PRODUCTIVE HOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	547,460					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,202	642,366				8.00
9.00	00900	HOUSEKEEPING	1,711	0	543,547			9.00
10.00	01000	DIETARY	17,407	0	17,407	1,062,353		10.00
11.00	01100	CAFETERIA	0	0	0	728,808	2,748,591	11.00
13.00	01300	NURSING ADMINISTRATION	6,620	0	6,620	0	72,710	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	19,306	0	19,306	0	33,099	14.00
15.00	01500	PHARMACY	2,854	0	2,854	0	106,224	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,408	0	4,408	0	21,745	16.00
17.00	01700	SOCIAL SERVICE	1,200	0	1,200	0	12,855	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	1,855	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	1,204	0	1,204	0	0	22.00
23.00	02300	PHARMACY RESIDENCY PROGRAM	538	0	538	0	3,506	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	182,133	49,711	182,133	270,414	1,061,941	30.00
31.00	03100	INTENSIVE CARE UNIT	21,319	12,940	21,319	39,080	199,871	31.00
40.00	04000	SUBPROVIDER - IPF	32,164	0	32,164	14,538	30,928	40.00
43.00	04300	NURSERY	5,875	33,930	5,875	8,397	19,358	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	60,646	169,380	60,646	0	216,320	50.00
51.00	05100	RECOVERY ROOM	0	13,468	0	0	22,777	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,403	113,963	2,403	1,116	62,251	52.00
52.01	05201	PERINATAL CLINIC	15,279	6,900	15,279	0	14,584	52.01
53.00	05300	ANESTHESIOLOGY	895	1,534	895	0	3,964	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,272	83,050	24,272	0	120,847	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	15,374	4,448	15,374	0	38,122	55.00
56.00	05600	RADIOISOTOPE	1,522	0	1,522	0	6,560	56.00
57.00	05700	CT SCAN	0	0	0	0	22,763	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,783	3,500	2,783	0	9,962	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,762	3,416	7,762	0	27,858	59.00
60.00	06000	LABORATORY	22,605	17,468	22,605	0	60,912	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	831	0	831	0	14,678	62.00
64.00	06400	INTRAVENOUS THERAPY	0	1,708	0	0	34,409	64.00
65.00	06500	RESPIRATORY THERAPY	8,108	0	8,108	0	70,277	65.00
66.00	06600	PHYSICAL THERAPY	7,988	1,400	7,988	0	0	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	0	25,011	66.01
67.00	06700	OCCUPATIONAL THERAPY	4,265	0	4,265	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	99	0	99	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	20,586	0	0	90,849	69.00
69.01	06901	CARDIAC REHABILITATION	10,506	0	10,506	0	13,910	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	688	0	688	0	862	70.00
70.01	07001	ELECTROSHOCK THERAPY	0	0	0	0	2,470	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,482	4,014	1,482	0	0	74.00
76.00	03330	ENDOSCOPY	4,126	19,252	4,126	0	24,963	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	26,079	0	26,079	0	66,477	90.00
91.00	09100	EMERGENCY	27,750	80,386	27,750	0	225,458	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	544,404	641,054	540,491	1,062,353	2,740,376	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,685	0	1,685	0	3,396	190.00
191.00	19100	RESEARCH	0	0	0	0	1,924	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,033	0	1,033	0	0	192.00
194.00	07951	NON-REIMBURSABLE	338	1,312	338	0	2,895	194.00
194.01	07950	RETAIL PHARMACY	0	0	0	0	0	194.01
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)	14,697,530	1,450,382	6,599,148	8,387,906	5,754,371	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	26.846765	2.257875	12.140897	7.895592	2.093571	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/16/2018 8:40 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (PRODUCTIVE HOURS)	
			7.00	8.00	9.00	10.00	11.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	1,439,878	51,526	136,985	486,408	333,692	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.630106	0.080213	0.252021	0.457859	0.121405	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: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/16/2018 8:40 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (PATIENT REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	1,796,094					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	51,500,273				14.00
15.00	01500	PHARMACY	105	0	1,334,459			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,467,665,334		16.00
17.00	01700	SOCIAL SERVICE	8	10,137	10,137	0	112,696	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PHARMACY RESIDENCY PROGRAM	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	876,555	331,099	2,617	190,451,961	91,366	30.00
31.00	03100	INTENSIVE CARE UNIT	187,258	92,228	1,085	40,692,648	13,204	31.00
40.00	04000	SUBPROVIDER - IPF	109,828	4,181	576	7,912,057	4,912	40.00
43.00	04300	NURSERY	14,697	0	0	4,191,163	2,837	43.00
44.00	04400	SKILLED NURSING FACILITY	0	229,319	198,805	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	145,545	299,020	98,459	134,789,455	0	50.00
51.00	05100	RECOVERY ROOM	19,931	8,588	3	13,451,653	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	40,440	0	0	12,992,579	377	52.00
52.01	05201	PERINATAL CLINIC	5,479	307	0	6,999,334	0	52.01
53.00	05300	ANESTHESIOLOGY	3,964	30,878	17	35,886,155	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,631	173,491	13,922	82,674,921	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,530	1,392	19	41,263,125	0	55.00
56.00	05600	RADIOISOTOPE	0	667,662	348	8,625,250	0	56.00
57.00	05700	CT SCAN	32	194,388	4,049	81,814,884	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3	81,395	0	26,663,339	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	20,457	645,542	87,793	47,687,365	0	59.00
60.00	06000	LABORATORY	9	1,606,958	0	119,175,611	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,281,586	64	13,793,832	0	62.00
64.00	06400	INTRAVENOUS THERAPY	31,639	8,910	107	12,855,307	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	314,638	5,121	30,558,369	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,041,298	0	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	283,831	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,717,240	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,560,138	0	68.00
69.00	06900	ELECTROCARDIOLOGY	66,947	47,089	388	69,801,747	0	69.00
69.01	06901	CARDIAC REHABILITATION	11,180	12	9	1,378,497	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	862	59	5	7,566,561	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	2,470	5	0	800,830	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	23,861,739	0	37,672,151	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	20,523,051	0	39,938,954	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	254,039,444	0	73.00
74.00	07400	RENAL DIALYSIS	0	6,615	34	6,038,137	0	74.00
76.00	03330	ENDOSCOPY	23,279	34,165	466	17,543,292	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,694	904,775	899,034	26,716,231	0	90.00
91.00	09100	EMERGENCY	191,554	140,782	11,139	79,087,975	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,794,097	51,500,011	1,334,197	1,467,665,334	112,696	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	1,924	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	NON-REIMBURSABLE	73	262	262	0	0	194.00
194.01	07950	RETAIL PHARMACY	0	0	0	0	0	194.01
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)	6,463,018	5,077,821	10,172,135	1,656,880	1,079,206	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.598374	0.098598	7.622666	0.001129	9.576258	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/16/2018 8:40 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (PATIENT REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	602,244	631,957	734,620	89,462	38,222	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.335308	0.012271	0.550500	0.000061	0.339160	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: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/16/2018 8:40 am

		Cost Center Description	INTERNS & RESIDENTS				
			SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)	PHARMACY RESIDENCY PROGRAM (ASSIGNED TIME)		
			21.00	22.00	23.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
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					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,180				21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD		1,180			22.00
23.00	02300	PHARMACY RESIDENCY PROGRAM			60		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	750	750	20		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	10		31.00
40.00	04000	SUBPROVIDER - IPF	0	0	10		40.00
43.00	04300	NURSERY	0	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	372	372	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
52.01	05201	PERINATAL CLINIC	0	0	0		52.01
53.00	05300	ANESTHESIOLOGY	10	10	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20	20	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	10	10	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
66.01	06601	CLINICAL NUTRITION	0	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	10		69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
70.01	07001	ELECTROSHOCK THERAPY	0	0	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03330	ENDOSCOPY	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	18	18	10		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,180	1,180	60		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
194.00	07951	NON-REIMBURSABLE	0	0	0		194.00
194.01	07950	RETAIL PHARMACY	0	0	0		194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/16/2018 8:40 am

		Cost Center Description	INTERNS & RESIDENTS				
			SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)	PHARMACY RESIDENCY PROGRAM (ASSIGNED TIME)		
			21.00	22.00	23.00		
202.00		Cost to be allocated (per Wkst. B, Part I)	1,458,414	168,664	252,600		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1,235.944068	142.935593	4,210.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	49,756	19,091	11,482		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	42.166102	16.178814	191.366667		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: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/16/2018 8:40 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	75,731,143		75,731,143	54,349	75,785,492	30.00
31.00	03100	INTENSIVE CARE UNIT	15,717,130		15,717,130	0	15,717,130	31.00
40.00	04000	SUBPROVIDER - IPF	4,708,945		4,708,945	0	4,708,945	40.00
43.00	04300	NURSERY	1,714,391		1,714,391	0	1,714,391	43.00
44.00	04400	SKILLED NURSING FACILITY	6,947,637		6,947,637	0	6,947,637	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,872,564		26,872,564	18,826	26,891,390	50.00
51.00	05100	RECOVERY ROOM	1,870,158		1,870,158	0	1,870,158	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,325,753		4,325,753	0	4,325,753	52.00
52.01	05201	PERINATAL CLINIC	1,941,788		1,941,788	0	1,941,788	52.01
53.00	05300	ANESTHESIOLOGY	1,063,244		1,063,244	33,967	1,097,211	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,587,620		13,587,620	0	13,587,620	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,983,558		6,983,558	0	6,983,558	55.00
56.00	05600	RADIOISOTOPE	1,667,025		1,667,025	0	1,667,025	56.00
57.00	05700	CT SCAN	2,209,845		2,209,845	0	2,209,845	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,140,738		2,140,738	0	2,140,738	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,019,130		5,019,130	0	5,019,130	59.00
60.00	06000	LABORATORY	6,783,061		6,783,061	0	6,783,061	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	4,219,220		4,219,220	0	4,219,220	62.00
64.00	06400	INTRAVENOUS THERAPY	3,648,370		3,648,370	0	3,648,370	64.00
65.00	06500	RESPIRATORY THERAPY	6,073,934	0	6,073,934	12,010	6,085,944	65.00
66.00	06600	PHYSICAL THERAPY	3,304,564	0	3,304,564	0	3,304,564	66.00
66.01	06601	CLINICAL NUTRITION	1,166,280	0	1,166,280	0	1,166,280	66.01
67.00	06700	OCCUPATIONAL THERAPY	1,532,747	0	1,532,747	0	1,532,747	67.00
68.00	06800	SPEECH PATHOLOGY	591,112	0	591,112	0	591,112	68.00
69.00	06900	ELECTROCARDIOLOGY	5,848,169		5,848,169	0	5,848,169	69.00
69.01	06901	CARDIAC REHABILITATION	1,708,141		1,708,141	1,038	1,709,179	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	758,707		758,707	0	758,707	70.00
70.01	07001	ELECTROSHOCK THERAPY	162,883		162,883	0	162,883	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	32,732,023		32,732,023	0	32,732,023	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,590,399		28,590,399	0	28,590,399	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40,009,891		40,009,891	0	40,009,891	73.00
74.00	07400	RENAL DIALYSIS	2,147,239		2,147,239	0	2,147,239	74.00
76.00	03330	ENDOSCOPY	2,571,139		2,571,139	0	2,571,139	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	21,519,829		21,519,829	29,594	21,549,423	90.00
91.00	09100	EMERGENCY	18,178,572		18,178,572	0	18,178,572	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,117,618		6,117,618		6,117,618	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	360,164,567	0	360,164,567	149,784	360,314,351	200.00
201.00		Less Observation Beds	6,117,618		6,117,618		6,117,618	201.00
202.00		Total (see instructions)	354,046,949	0	354,046,949	149,784	354,196,733	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I | Date/Time Prepared: 5/16/2018 8:40 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	183,322,387		183,322,387			30.00
31.00	03100	INTENSIVE CARE UNIT	39,446,014		39,446,014			31.00
40.00	04000	SUBPROVIDER - IPF	7,665,665		7,665,665			40.00
43.00	04300	NURSERY	4,073,950		4,073,950			43.00
44.00	04400	SKILLED NURSING FACILITY	4,253,608		4,253,608			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	61,826,033	63,425,055	125,251,088	0.214550	0.000000	50.00
51.00	05100	RECOVERY ROOM	7,584,600	4,985,137	12,569,737	0.148783	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,358,623	4,361,672	12,720,295	0.340067	0.000000	52.00
52.01	05201	PERINATAL CLINIC	56,523	6,427,153	6,483,676	0.299489	0.000000	52.01
53.00	05300	ANESTHESIOLOGY	15,131,172	18,602,257	33,733,429	0.031519	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,830,294	51,147,487	77,977,781	0.174250	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	967,652	38,647,468	39,615,120	0.176285	0.000000	55.00
56.00	05600	RADIOISOTOPE	4,221,715	4,076,463	8,298,178	0.200890	0.000000	56.00
57.00	05700	CT SCAN	33,295,583	45,468,066	78,763,649	0.028057	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	8,445,192	16,623,243	25,068,435	0.085396	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	26,585,394	19,138,196	45,723,590	0.109771	0.000000	59.00
60.00	06000	LABORATORY	71,418,971	42,980,464	114,399,435	0.059293	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	10,541,030	2,723,234	13,264,264	0.318089	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	681,107	11,373,155	12,054,262	0.302662	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	21,985,701	7,225,250	29,210,951	0.207933	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	6,843,293	924,882	7,768,175	0.425398	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	0	253,833	253,833	4.594674	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	3,042,225	572,349	3,614,574	0.424046	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,281,269	214,918	2,496,187	0.236806	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	25,475,498	41,794,394	67,269,892	0.086936	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	432,209	874,829	1,307,038	1.306879	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	3,765,538	3,440,339	7,205,877	0.105290	0.000000	70.00
70.01	07001	ELECTROSHOCK THERAPY	211,765	541,292	753,057	0.216296	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	27,348,119	9,534,540	36,882,659	0.887464	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,167,800	9,934,158	39,101,958	0.731176	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	69,051,560	179,664,004	248,715,564	0.160866	0.000000	73.00
74.00	07400	RENAL DIALYSIS	5,370,436	512,842	5,883,278	0.364973	0.000000	74.00
76.00	03330	ENDOSCOPY	3,910,613	12,403,020	16,313,633	0.157607	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	61,302	25,159,623	25,220,925	0.853253	0.000000	90.00
91.00	09100	EMERGENCY	34,166,223	41,715,759	75,881,982	0.239564	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5,445,195	25,312,528	30,757,723	0.198897	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	753,264,259	690,057,610	1,443,321,869			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	753,264,259	690,057,610	1,443,321,869			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/16/2018 8:40 am

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		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.214700		50.00
51.00	05100	RECOVERY ROOM	0.148783		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.340067		52.00
52.01	05201	PERINATAL CLINIC	0.299489		52.01
53.00	05300	ANESTHESIOLOGY	0.032526		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174250		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.176285		55.00
56.00	05600	RADIOISOTOPE	0.200890		56.00
57.00	05700	CT SCAN	0.028057		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.085396		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.109771		59.00
60.00	06000	LABORATORY	0.059293		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.318089		62.00
64.00	06400	INTRAVENOUS THERAPY	0.302662		64.00
65.00	06500	RESPIRATORY THERAPY	0.208345		65.00
66.00	06600	PHYSICAL THERAPY	0.425398		66.00
66.01	06601	CLINICAL NUTRITION	4.594674		66.01
67.00	06700	OCCUPATIONAL THERAPY	0.424046		67.00
68.00	06800	SPEECH PATHOLOGY	0.236806		68.00
69.00	06900	ELECTROCARDIOLOGY	0.086936		69.00
69.01	06901	CARDIAC REHABILITATION	1.307674		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.105290		70.00
70.01	07001	ELECTROSHOCK THERAPY	0.216296		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.887464		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.731176		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.160866		73.00
74.00	07400	RENAL DIALYSIS	0.364973		74.00
76.00	03330	ENDOSCOPY	0.157607		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.854426		90.00
91.00	09100	EMERGENCY	0.239564		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.198897		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/16/2018 8:40 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	75,731,143		75,731,143	54,349	75,785,492	30.00
31.00	03100	INTENSIVE CARE UNIT	15,717,130		15,717,130	0	15,717,130	31.00
40.00	04000	SUBPROVIDER - IPF	4,708,945		4,708,945	0	4,708,945	40.00
43.00	04300	NURSERY	1,714,391		1,714,391	0	1,714,391	43.00
44.00	04400	SKILLED NURSING FACILITY	6,947,637		6,947,637	0	6,947,637	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,872,564		26,872,564	18,826	26,891,390	50.00
51.00	05100	RECOVERY ROOM	1,870,158		1,870,158	0	1,870,158	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,325,753		4,325,753	0	4,325,753	52.00
52.01	05201	PERINATAL CLINIC	1,941,788		1,941,788	0	1,941,788	52.01
53.00	05300	ANESTHESIOLOGY	1,063,244		1,063,244	33,967	1,097,211	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,587,620		13,587,620	0	13,587,620	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,983,558		6,983,558	0	6,983,558	55.00
56.00	05600	RADIOISOTOPE	1,667,025		1,667,025	0	1,667,025	56.00
57.00	05700	CT SCAN	2,209,845		2,209,845	0	2,209,845	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,140,738		2,140,738	0	2,140,738	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,019,130		5,019,130	0	5,019,130	59.00
60.00	06000	LABORATORY	6,783,061		6,783,061	0	6,783,061	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	4,219,220		4,219,220	0	4,219,220	62.00
64.00	06400	INTRAVENOUS THERAPY	3,648,370		3,648,370	0	3,648,370	64.00
65.00	06500	RESPIRATORY THERAPY	6,073,934	0	6,073,934	12,010	6,085,944	65.00
66.00	06600	PHYSICAL THERAPY	3,304,564	0	3,304,564	0	3,304,564	66.00
66.01	06601	CLINICAL NUTRITION	1,166,280	0	1,166,280	0	1,166,280	66.01
67.00	06700	OCCUPATIONAL THERAPY	1,532,747	0	1,532,747	0	1,532,747	67.00
68.00	06800	SPEECH PATHOLOGY	591,112	0	591,112	0	591,112	68.00
69.00	06900	ELECTROCARDIOLOGY	5,848,169		5,848,169	0	5,848,169	69.00
69.01	06901	CARDIAC REHABILITATION	1,708,141		1,708,141	1,038	1,709,179	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	758,707		758,707	0	758,707	70.00
70.01	07001	ELECTROSHOCK THERAPY	162,883		162,883	0	162,883	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	32,732,023		32,732,023	0	32,732,023	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,590,399		28,590,399	0	28,590,399	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40,009,891		40,009,891	0	40,009,891	73.00
74.00	07400	RENAL DIALYSIS	2,147,239		2,147,239	0	2,147,239	74.00
76.00	03330	ENDOSCOPY	2,571,139		2,571,139	0	2,571,139	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	21,519,829		21,519,829	29,594	21,549,423	90.00
91.00	09100	EMERGENCY	18,178,572		18,178,572	0	18,178,572	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,117,618		6,117,618		6,117,618	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	360,164,567	0	360,164,567	149,784	360,314,351	200.00
201.00		Less Observation Beds	6,117,618		6,117,618		6,117,618	201.00
202.00		Total (see instructions)	354,046,949	0	354,046,949	149,784	354,196,733	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/16/2018 8:40 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	183,322,387		183,322,387			30.00
31.00	03100	INTENSIVE CARE UNIT	39,446,014		39,446,014			31.00
40.00	04000	SUBPROVIDER - IPF	7,665,665		7,665,665			40.00
43.00	04300	NURSERY	4,073,950		4,073,950			43.00
44.00	04400	SKILLED NURSING FACILITY	4,253,608		4,253,608			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	61,826,033	63,425,055	125,251,088	0.214550	0.000000	50.00
51.00	05100	RECOVERY ROOM	7,584,600	4,985,137	12,569,737	0.148783	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,358,623	4,361,672	12,720,295	0.340067	0.000000	52.00
52.01	05201	PERINATAL CLINIC	56,523	6,427,153	6,483,676	0.299489	0.000000	52.01
53.00	05300	ANESTHESIOLOGY	15,131,172	18,602,257	33,733,429	0.031519	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,830,294	51,147,487	77,977,781	0.174250	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	967,652	38,647,468	39,615,120	0.176285	0.000000	55.00
56.00	05600	RADIOISOTOPE	4,221,715	4,076,463	8,298,178	0.200890	0.000000	56.00
57.00	05700	CT SCAN	33,295,583	45,468,066	78,763,649	0.028057	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	8,445,192	16,623,243	25,068,435	0.085396	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	26,585,394	19,138,196	45,723,590	0.109771	0.000000	59.00
60.00	06000	LABORATORY	71,418,971	42,980,464	114,399,435	0.059293	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	10,541,030	2,723,234	13,264,264	0.318089	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	681,107	11,373,155	12,054,262	0.302662	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	21,985,701	7,225,250	29,210,951	0.207933	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	6,843,293	924,882	7,768,175	0.425398	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	0	253,833	253,833	4.594674	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	3,042,225	572,349	3,614,574	0.424046	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,281,269	214,918	2,496,187	0.236806	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	25,475,498	41,794,394	67,269,892	0.086936	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	432,209	874,829	1,307,038	1.306879	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	3,765,538	3,440,339	7,205,877	0.105290	0.000000	70.00
70.01	07001	ELECTROSHOCK THERAPY	211,765	541,292	753,057	0.216296	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	27,348,119	9,534,540	36,882,659	0.887464	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,167,800	9,934,158	39,101,958	0.731176	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	69,051,560	179,664,004	248,715,564	0.160866	0.000000	73.00
74.00	07400	RENAL DIALYSIS	5,370,436	512,842	5,883,278	0.364973	0.000000	74.00
76.00	03330	ENDOSCOPY	3,910,613	12,403,020	16,313,633	0.157607	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	61,302	25,159,623	25,220,925	0.853253	0.000000	90.00
91.00	09100	EMERGENCY	34,166,223	41,715,759	75,881,982	0.239564	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5,445,195	25,312,528	30,757,723	0.198897	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	753,264,259	690,057,610	1,443,321,869			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	753,264,259	690,057,610	1,443,321,869			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/16/2018 8:40 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
52.01	05201	PERINATAL CLINIC	0.000000		52.01
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
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
66.01	06601	CLINICAL NUTRITION	0.000000		66.01
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
69.01	06901	CARDIAC REHABILITATION	0.000000		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
70.01	07001	ELECTROSHOCK THERAPY	0.000000		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.00	03330	ENDOSCOPY	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
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
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part I Date/Time Prepared: 5/16/2018 8:40 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	4,536,977	0	4,536,977	99,389	45.65	30.00
31.00	INTENSIVE CARE UNIT	819,883		819,883	13,204	62.09	31.00
40.00	SUBPROVIDER - IPF	576,424	0	576,424	4,912	117.35	40.00
43.00	NURSERY	117,522		117,522	2,837	41.42	43.00
44.00	SKILLED NURSING FACILITY	326,170		326,170	16,890	19.31	44.00
200.00	Total (lines 30 through 199)	6,376,976		6,376,976	137,232		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	31,184	1,423,550		30.00
31.00	INTENSIVE CARE UNIT	1,677	104,125		31.00
40.00	SUBPROVIDER - IPF	1,777	208,531		40.00
43.00	NURSERY	0	0		43.00
44.00	SKILLED NURSING FACILITY	2,913	56,250		44.00
200.00	Total (lines 30 through 199)	37,551	1,792,456		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/16/2018 8:40 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,573,133	125,251,088	0.028528	27,235,966	776,988	50.00
51.00	05100	RECOVERY ROOM	39,429	12,569,737	0.003137	2,835,822	8,896	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	120,553	12,720,295	0.009477	31,226	296	52.00
52.01	05201	PERINATAL CLINIC	396,480	6,483,676	0.061150	0	0	52.01
53.00	05300	ANESTHESIOLOGY	172,368	33,733,429	0.005110	4,527,469	23,135	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,243,421	77,977,781	0.015946	6,308,846	100,601	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,283,710	39,615,120	0.057647	354,972	20,463	55.00
56.00	05600	RADIOISOTOPE	139,664	8,298,178	0.016831	1,647,280	27,725	56.00
57.00	05700	CT SCAN	247,553	78,763,649	0.003143	11,387,521	35,791	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,005,244	25,068,435	0.040100	2,995,411	120,116	58.00
59.00	05900	CARDIAC CATHETERIZATION	466,774	45,723,590	0.010209	6,014,711	61,404	59.00
60.00	06000	LABORATORY	583,075	114,399,435	0.005097	25,951,398	132,274	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	93,112	13,264,264	0.007020	2,730,998	19,172	62.00
64.00	06400	INTRAVENOUS THERAPY	397,522	12,054,262	0.032978	41,374	1,364	64.00
65.00	06500	RESPIRATORY THERAPY	473,727	29,210,951	0.016217	6,859,874	111,247	65.00
66.00	06600	PHYSICAL THERAPY	159,105	7,768,175	0.020482	2,484,631	50,890	66.00
66.01	06601	CLINICAL NUTRITION	19,565	253,833	0.077078	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	81,496	3,614,574	0.022547	1,009,167	22,754	67.00
68.00	06800	SPEECH PATHOLOGY	11,286	2,496,187	0.004521	915,404	4,139	68.00
69.00	06900	ELECTROCARDIOLOGY	546,333	67,269,892	0.008122	8,471,937	68,809	69.00
69.01	06901	CARDIAC REHABILITATION	184,746	1,307,038	0.141347	54,016	7,635	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	164,878	7,205,877	0.022881	1,207,214	27,622	70.00
70.01	07001	ELECTROSHOCK THERAPY	4,929	753,057	0.006545	53,716	352	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	739,537	36,882,659	0.020051	10,791,170	216,374	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	642,816	39,101,958	0.016439	10,518,002	172,905	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	597,372	248,715,564	0.002402	22,922,224	55,059	73.00
74.00	07400	RENAL DIALYSIS	54,485	5,883,278	0.009261	3,149,001	29,163	74.00
76.00	03330	ENDOSCOPY	482,432	16,313,633	0.029572	1,143,341	33,811	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,190,454	25,220,925	0.086851	890	77	90.00
91.00	09100	EMERGENCY	997,118	75,881,982	0.013140	5,274,177	69,303	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	366,237	30,757,723	0.011907	3,058,937	36,423	92.00
200.00		Total (lines 50 through 199)	18,478,554	1,204,560,245		169,976,695	2,234,788	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part III Date/Time Prepared: 5/16/2018 8:40 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	84,200	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	42,100	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	42,100	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
200.00		Total (lines 30 through 199)	0	0	0	168,400	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	84,200	99,389	0.85	31,184	30.00
31.00	03100	INTENSIVE CARE UNIT		42,100	13,204	3.19	1,677	31.00
40.00	04000	SUBPROVIDER - IPF	0	42,100	4,912	8.57	1,777	40.00
43.00	04300	NURSERY		0	2,837	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	16,890	0.00	2,913	44.00
200.00		Total (lines 30 through 199)		168,400	137,232		37,551	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	26,506	30.00
31.00	03100	INTENSIVE CARE UNIT	5,350	31.00
40.00	04000	SUBPROVIDER - IPF	15,229	40.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	47,085	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/16/2018 8:40 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	PERINATAL CLINIC	0	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	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	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	42,100	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	42,100	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		6,797	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	90,997	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/16/2018 8:40 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	125,251,088	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	12,569,737	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	12,720,295	0.000000	52.00
52.01	05201	PERINATAL CLINIC	0	0	0	6,483,676	0.000000	52.01
53.00	05300	ANESTHESIOLOGY	0	0	0	33,733,429	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	77,977,781	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	39,615,120	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	8,298,178	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	78,763,649	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	25,068,435	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	45,723,590	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	114,399,435	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	13,264,264	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	12,054,262	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	29,210,951	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,768,175	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	253,833	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,614,574	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,496,187	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	42,100	42,100	67,269,892	0.000626	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	1,307,038	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	7,205,877	0.000000	70.00
70.01	07001	ELECTROSHOCK THERAPY	0	0	0	753,057	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	36,882,659	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	39,101,958	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	248,715,564	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	5,883,278	0.000000	74.00
76.00	03330	ENDOSCOPY	0	0	0	16,313,633	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	25,220,925	0.000000	90.00
91.00	09100	EMERGENCY	0	42,100	42,100	75,881,982	0.000555	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,797	6,797	30,757,723	0.000221	92.00
200.00		Total (lines 50 through 199)	0	90,997	90,997	1,204,560,245		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/16/2018 8:40 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	27,235,966	0	34,134,051	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	2,835,822	0	4,013,331	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	31,226	0	0	0	52.00
52.01	05201	PERINATAL CLINIC	0.000000	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.000000	4,527,469	0	3,027,983	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	6,308,846	0	8,599,286	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	354,972	0	13,822,457	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	1,647,280	0	1,747,166	0	56.00
57.00	05700	CT SCAN	0.000000	11,387,521	0	9,199,636	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	2,995,411	0	4,933,642	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	6,014,711	0	3,970,226	0	59.00
60.00	06000	LABORATORY	0.000000	25,951,398	0	8,048,902	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	2,730,998	0	302,485	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	41,374	0	1,562,071	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	6,859,874	0	1,096,284	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	2,484,631	0	92,810	0	66.00
66.01	06601	CLINICAL NUTRITION	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,009,167	0	32,893	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	915,404	0	22,816	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000626	8,471,937	5,303	4,854,532	3,039	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	54,016	0	322,612	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	1,207,214	0	893,489	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.000000	53,716	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	10,791,170	0	4,063,501	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	10,518,002	0	2,969,628	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	22,922,224	0	66,292,049	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	3,149,001	0	231,428	0	74.00
76.00	03330	ENDOSCOPY	0.000000	1,143,341	0	1,957,453	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	890	0	5,159,691	0	90.00
91.00	09100	EMERGENCY	0.000555	5,274,177	2,927	6,772,064	3,758	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000221	3,058,937	676	6,371,250	1,408	92.00
200.00		Total (lines 50 through 199)		169,976,695	8,906	194,493,736	8,205	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/16/2018 8:40 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.214550	34,134,051	0	0	7,323,461	50.00
51.00	05100	RECOVERY ROOM	0.148783	4,013,331	0	0	597,115	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.340067	0	0	0	0	52.00
52.01	05201	PERINATAL CLINIC	0.299489	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.031519	3,027,983	0	0	95,439	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174250	8,599,286	0	0	1,498,426	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.176285	13,822,457	0	0	2,436,692	55.00
56.00	05600	RADIOISOTOPE	0.200890	1,747,166	0	0	350,988	56.00
57.00	05700	CT SCAN	0.028057	9,199,636	0	0	258,114	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.085396	4,933,642	0	0	421,313	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.109771	3,970,226	0	0	435,816	59.00
60.00	06000	LABORATORY	0.059293	8,048,902	0	0	477,244	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.318089	302,485	0	0	96,217	62.00
64.00	06400	INTRAVENOUS THERAPY	0.302662	1,562,071	0	0	472,780	64.00
65.00	06500	RESPIRATORY THERAPY	0.207933	1,096,284	0	0	227,954	65.00
66.00	06600	PHYSICAL THERAPY	0.425398	92,810	0	0	39,481	66.00
66.01	06601	CLINICAL NUTRITION	4.594674	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.424046	32,893	0	0	13,948	67.00
68.00	06800	SPEECH PATHOLOGY	0.236806	22,816	0	0	5,403	68.00
69.00	06900	ELECTROCARDIOLOGY	0.086936	4,854,532	0	0	422,034	69.00
69.01	06901	CARDIAC REHABILITATION	1.306879	322,612	0	0	421,615	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.105290	893,489	0	0	94,075	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.216296	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.887464	4,063,501	0	0	3,606,211	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.731176	2,969,628	0	0	2,171,321	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.160866	66,292,049	2,283	532,910	10,664,137	73.00
74.00	07400	RENAL DIALYSIS	0.364973	231,428	0	0	84,465	74.00
76.00	03330	ENDOSCOPY	0.157607	1,957,453	0	0	308,508	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.853253	5,159,691	0	0	4,402,522	90.00
91.00	09100	EMERGENCY	0.239564	6,772,064	0	0	1,622,343	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.198897	6,371,250	0	0	1,267,223	92.00
200.00		Subtotal (see instructions)		194,493,736	2,283	532,910	39,814,845	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		194,493,736	2,283	532,910	39,814,845	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/16/2018 8:40 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
52.01	05201	PERINATAL CLINIC	0	0		52.01
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
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
66.01	06601	CLINICAL NUTRITION	0	0		66.01
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
69.01	06901	CARDIAC REHABILITATION	0	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01	07001	ELECTROSHOCK THERAPY	0	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	367	85,727		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03330	ENDOSCOPY	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	367	85,727		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	367	85,727		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 26-0104 | Component CCN: 26-S104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/16/2018 8:40 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,573,133	125,251,088	0.028528	11,722	334	50.00
51.00	05100	RECOVERY ROOM	39,429	12,569,737	0.003137	1,140	4	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	120,553	12,720,295	0.009477	0	0	52.00
52.01	05201	PERINATAL CLINIC	396,480	6,483,676	0.061150	0	0	52.01
53.00	05300	ANESTHESIOLOGY	172,368	33,733,429	0.005110	8,556	44	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,243,421	77,977,781	0.015946	13,103	209	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,283,710	39,615,120	0.057647	356	21	55.00
56.00	05600	RADIOISOTOPE	139,664	8,298,178	0.016831	0	0	56.00
57.00	05700	CT SCAN	247,553	78,763,649	0.003143	24,900	78	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,005,244	25,068,435	0.040100	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	466,774	45,723,590	0.010209	0	0	59.00
60.00	06000	LABORATORY	583,075	114,399,435	0.005097	363,721	1,854	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	93,112	13,264,264	0.007020	2,676	19	62.00
64.00	06400	INTRAVENOUS THERAPY	397,522	12,054,262	0.032978	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	473,727	29,210,951	0.016217	5,844	95	65.00
66.00	06600	PHYSICAL THERAPY	159,105	7,768,175	0.020482	513	11	66.00
66.01	06601	CLINICAL NUTRITION	19,565	253,833	0.077078	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	81,496	3,614,574	0.022547	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	11,286	2,496,187	0.004521	1,315	6	68.00
69.00	06900	ELECTROCARDIOLOGY	546,333	67,269,892	0.008122	6,706	54	69.00
69.01	06901	CARDIAC REHABILITATION	184,746	1,307,038	0.141347	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	164,878	7,205,877	0.022881	1,093	25	70.00
70.01	07001	ELECTROSHOCK THERAPY	4,929	753,057	0.006545	29,957	196	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	739,537	36,882,659	0.020051	1,267	25	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	642,816	39,101,958	0.016439	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	597,372	248,715,564	0.002402	590,657	1,419	73.00
74.00	07400	RENAL DIALYSIS	54,485	5,883,278	0.009261	36,456	338	74.00
76.00	03330	ENDOSCOPY	482,432	16,313,633	0.029572	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,190,454	25,220,925	0.086851	0	0	90.00
91.00	09100	EMERGENCY	997,118	75,881,982	0.013140	167,912	2,206	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	30,757,723	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	18,112,317	1,204,560,245		1,267,894	6,938	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0104 | Component CCN: 26-S104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/16/2018 8:40 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	PERINATAL CLINIC	0	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	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	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	42,100	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	42,100	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	84,200	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0104 | Component CCN: 26-S104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/16/2018 8:40 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	125,251,088	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	12,569,737	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	12,720,295	0.000000	52.00
52.01	05201	PERINATAL CLINIC	0	0	0	6,483,676	0.000000	52.01
53.00	05300	ANESTHESIOLOGY	0	0	0	33,733,429	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	77,977,781	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	39,615,120	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	8,298,178	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	78,763,649	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	25,068,435	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	45,723,590	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	114,399,435	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	13,264,264	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	12,054,262	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	29,210,951	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,768,175	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	253,833	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,614,574	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,496,187	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	42,100	42,100	67,269,892	0.000626	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	1,307,038	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	7,205,877	0.000000	70.00
70.01	07001	ELECTROSHOCK THERAPY	0	0	0	753,057	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	36,882,659	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	39,101,958	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	248,715,564	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	5,883,278	0.000000	74.00
76.00	03330	ENDOSCOPY	0	0	0	16,313,633	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	25,220,925	0.000000	90.00
91.00	09100	EMERGENCY	0	42,100	42,100	75,881,982	0.000555	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	30,757,723	0.000000	92.00
200.00		Total (lines 50 through 199)	0	84,200	84,200	1,204,560,245		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0104 | Component CCN: 26-S104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/16/2018 8:40 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	11,722	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	1,140	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
52.01	05201	PERINATAL CLINIC	0.000000	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.000000	8,556	0	26,982	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	13,103	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	356	0	147	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	24,900	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	363,721	0	186	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	2,676	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	5,844	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	513	0	0	0	66.00
66.01	06601	CLINICAL NUTRITION	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	1,315	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000626	6,706	4	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	1,093	0	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.000000	29,957	0	100,201	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,267	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	590,657	0	3,283,604	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	36,456	0	0	0	74.00
76.00	03330	ENDOSCOPY	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000555	167,912	93	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,267,894	97	3,411,120	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 26-0104 | Component CCN: 26-S104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V | Date/Time Prepared: 5/16/2018 8:40 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.214550	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.148783	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.340067	0	0	0	0	52.00
52.01	05201	PERINATAL CLINIC	0.299489	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.031519	26,982	0	0	850	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174250	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.176285	147	0	0	26	55.00
56.00	05600	RADIOISOTOPE	0.200890	0	0	0	0	56.00
57.00	05700	CT SCAN	0.028057	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.085396	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.109771	0	0	0	0	59.00
60.00	06000	LABORATORY	0.059293	186	0	0	11	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.318089	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.302662	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.207933	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.425398	0	0	0	0	66.00
66.01	06601	CLINICAL NUTRITION	4.594674	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.424046	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.236806	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.086936	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	1.306879	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.105290	0	0	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.216296	100,201	0	0	21,673	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.887464	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.731176	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.160866	3,283,604	0	0	528,220	73.00
74.00	07400	RENAL DIALYSIS	0.364973	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	0.157607	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.853253	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.239564	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.198897	0	0	0	0	92.00
200.00		Subtotal (see instructions)		3,411,120	0	0	550,780	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		3,411,120	0	0	550,780	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 26-0104 | Component CCN: 26-S104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V | Date/Time Prepared: 5/16/2018 8:40 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
52.01	05201	PERINATAL CLINIC	0	0		52.01
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
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
66.01	06601	CLINICAL NUTRITION	0	0		66.01
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
69.01	06901	CARDIAC REHABILITATION	0	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01	07001	ELECTROSHOCK THERAPY	0	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03330	ENDOSCOPY	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0104 | Component CCN: 26-5842 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/16/2018 8:40 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	PERINATAL CLINIC	0	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	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	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	42,100	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	42,100	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	84,200	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0104 | Component CCN: 26-5842 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/16/2018 8:40 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	125,251,088	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	12,569,737	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	12,720,295	0.000000	52.00
52.01	05201	PERINATAL CLINIC	0	0	0	6,483,676	0.000000	52.01
53.00	05300	ANESTHESIOLOGY	0	0	0	33,733,429	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	77,977,781	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	39,615,120	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	8,298,178	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	78,763,649	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	25,068,435	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	45,723,590	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	114,399,435	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	13,264,264	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	12,054,262	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	29,210,951	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,768,175	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	253,833	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,614,574	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,496,187	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	42,100	42,100	67,269,892	0.000626	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	1,307,038	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	7,205,877	0.000000	70.00
70.01	07001	ELECTROSHOCK THERAPY	0	0	0	753,057	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	36,882,659	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	39,101,958	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	248,715,564	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	5,883,278	0.000000	74.00
76.00	03330	ENDOSCOPY	0	0	0	16,313,633	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	25,220,925	0.000000	90.00
91.00	09100	EMERGENCY	0	42,100	42,100	75,881,982	0.000555	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	30,757,723	0.000000	92.00
200.00		Total (lines 50 through 199)	0	84,200	84,200	1,204,560,245		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0104 | Component CCN: 26-5842 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/16/2018 8:40 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	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
52.01	05201	PERINATAL CLINIC	0.000000	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	4,954	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	5,841	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	62.00
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	342,272	0	0	0	66.00
66.01	06601	CLINICAL NUTRITION	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	351,542	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	127,779	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000626	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.000000	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	13,709	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	122,350	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000555	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		968,447	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/16/2018 8:40 am

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.214550	0	1,297,699	0	0	50.00
51.00	05100	RECOVERY ROOM	0.148783	0	477,035	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.340067	0	416,634	0	0	52.00
52.01	05201	PERINATAL CLINIC	0.299489	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.031519	0	318,759	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174250	0	2,324,735	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.176285	0	2,038,702	0	0	55.00
56.00	05600	RADIOISOTOPE	0.200890	0	167,886	0	0	56.00
57.00	05700	CT SCAN	0.028057	0	3,477,321	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.085396	0	588,518	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.109771	0	905,807	0	0	59.00
60.00	06000	LABORATORY	0.059293	0	3,991,856	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.318089	0	222,325	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.302662	0	771,309	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.207933	0	331,624	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.425398	0	7,713	0	0	66.00
66.01	06601	CLINICAL NUTRITION	4.594674	0	1,948	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.424046	0	4,452	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.236806	0	3,593	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.086936	0	1,349,324	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	1.306879	0	43,545	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.105290	0	112,981	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.216296	0	126,026	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.887464	0	391,255	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.731176	0	301,199	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.160866	0	9,262,990	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.364973	0	166,656	0	0	74.00
76.00	03330	ENDOSCOPY	0.157607	0	174,418	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.853253	0	369,610	0	0	90.00
91.00	09100	EMERGENCY	0.239564	0	5,762,200	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.198897	0	2,360,886	0	0	92.00
200.00		Subtotal (see instructions)		0	37,769,006	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	37,769,006	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/16/2018 8:40 am

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	278,421	0		50.00
51.00	05100	RECOVERY ROOM	70,975	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	141,683	0		52.00
52.01	05201	PERINATAL CLINIC	0	0		52.01
53.00	05300	ANESTHESIOLOGY	10,047	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	405,085	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	359,393	0		55.00
56.00	05600	RADIOISOTOPE	33,727	0		56.00
57.00	05700	CT SCAN	97,563	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	50,257	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	99,431	0		59.00
60.00	06000	LABORATORY	236,689	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	70,719	0		62.00
64.00	06400	INTRAVENOUS THERAPY	233,446	0		64.00
65.00	06500	RESPIRATORY THERAPY	68,956	0		65.00
66.00	06600	PHYSICAL THERAPY	3,281	0		66.00
66.01	06601	CLINICAL NUTRITION	8,950	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	1,888	0		67.00
68.00	06800	SPEECH PATHOLOGY	851	0		68.00
69.00	06900	ELECTROCARDIOLOGY	117,305	0		69.00
69.01	06901	CARDIAC REHABILITATION	56,908	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	11,896	0		70.00
70.01	07001	ELECTROSHOCK THERAPY	27,259	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	347,225	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	220,229	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,490,100	0		73.00
74.00	07400	RENAL DIALYSIS	60,825	0		74.00
76.00	03330	ENDOSCOPY	27,489	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	315,371	0		90.00
91.00	09100	EMERGENCY	1,380,416	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	469,573	0		92.00
200.00		Subtotal (see instructions)	6,695,958	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,695,958	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0104 | Component CCN: 26-5842 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/16/2018 8:40 am

Title XIX | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	PERINATAL CLINIC	0	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	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	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	42,100	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	42,100	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	84,200	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0104 | Component CCN: 26-5842 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/16/2018 8:40 am

Title XIX | Skilled Nursing Facility | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	125,251,088	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	12,569,737	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	12,720,295	0.000000	52.00
52.01	05201	PERINATAL CLINIC	0	0	0	6,483,676	0.000000	52.01
53.00	05300	ANESTHESIOLOGY	0	0	0	33,733,429	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	77,977,781	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	39,615,120	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	8,298,178	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	78,763,649	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	25,068,435	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	45,723,590	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	114,399,435	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	13,264,264	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	12,054,262	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	29,210,951	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,768,175	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	253,833	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,614,574	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,496,187	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	42,100	42,100	67,269,892	0.000626	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	1,307,038	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	7,205,877	0.000000	70.00
70.01	07001	ELECTROSHOCK THERAPY	0	0	0	753,057	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	36,882,659	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	39,101,958	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	248,715,564	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	5,883,278	0.000000	74.00
76.00	03330	ENDOSCOPY	0	0	0	16,313,633	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	25,220,925	0.000000	90.00
91.00	09100	EMERGENCY	0	42,100	42,100	75,881,982	0.000555	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	30,757,723	0.000000	92.00
200.00		Total (lines 50 through 199)	0	84,200	84,200	1,204,560,245		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0104 | Component CCN: 26-5842 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/16/2018 8:40 am

Title XIX | Skilled Nursing Facility | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	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
52.01	05201	PERINATAL CLINIC	0.000000	0	0	0	0	52.01
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	62.00
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
66.01	06601	CLINICAL NUTRITION	0.000000	0	0	0	0	66.01
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	0.000626	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.000000	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.00	03330	ENDOSCOPY	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000555	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 26-0104	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/16/2018 8:40 am
	Title XVIII	Hospital	PPS

	Cost Center Description		
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	99,389	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	99,389	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.	74,013	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	17,353	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)	31,184	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	75,785,492	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)	75,785,492	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	183,322,389	28.00
29.00	Private room charges (excluding swing-bed charges)	154,942,808	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	28,379,581	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.413400	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	2,093.45	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,635.43	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	458.02	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	189.35	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	14,014,362	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	61,771,130	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	762.51	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	23,778,112	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)	23,778,112	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/16/2018 8:40 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	15,717,130	13,204	1,190.33	1,677	1,996,183	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	39,809,300	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	65,583,595	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,559,531	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	2,243,694	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	3,803,225	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	61,780,370	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	8,023	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	762.51	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	6,117,618	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/16/2018 8:40 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	4,536,977	75,785,492	0.059866	6,117,618	366,237	90.00
91.00	Nursing School cost	0	75,785,492	0.000000	6,117,618	0	91.00
92.00	Allied health cost	84,200	75,785,492	0.001111	6,117,618	6,797	92.00
93.00	All other Medical Education	0	75,785,492	0.000000	6,117,618	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 26-0104 Component CCN: 26-S104	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/16/2018 8:40 am
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,912	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,912	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.	365	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,547	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,777	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,708,945	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)	4,708,945	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	7,665,665	28.00
29.00	Private room charges (excluding swing-bed charges)	569,698	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	7,095,967	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.614290	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	1,560.82	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,560.58	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.24	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.15	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	55	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,708,890	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	958.66	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,703,539	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,703,539	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1

Component CCN: 26-S104 | Date/Time Prepared: 5/16/2018 8:40 am

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	187,024	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,890,563	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)	223,760	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	7,035	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	230,795	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,659,768	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1

Component CCN: 26-S104 | Date/Time Prepared: 5/16/2018 8:40 am

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	576,424	4,708,945	0.122410	0	0	90.00
91.00	Nursing School cost	0	4,708,945	0.000000	0	0	91.00
92.00	Allied health cost	42,100	4,708,945	0.008940	0	0	92.00
93.00	All other Medical Education	0	4,708,945	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 26-0104 Component CCN: 26-5842	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/16/2018 8:40 am
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	16,890	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	16,890	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)	16,890	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,913	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,947,637	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)	6,947,637	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,947,637	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-0104 | Component CCN: 26-5842 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/16/2018 8:40 am

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		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		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)	6,947,637	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	411.35	71.00
72.00	Program routine service cost (line 9 x line 71)	1,198,263	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	1,198,263	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	1,198,263	83.00
84.00	Program inpatient ancillary services (see instructions)	357,988	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	1,556,251	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 26-0104 Component CCN: 26-5842	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/16/2018 8:40 am
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 26-0104	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/16/2018 8:40 am
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	99,389	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	99,389	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.	74,013	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	17,353	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)	14,955	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)	2,837	15.00
16.00	Nursery days (title V or XIX only)	340	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	75,731,143	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)	75,731,143	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	28,234,654	28.00
29.00	Private room charges (excluding swing-bed charges)	23,863,733	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	4,370,921	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	2.682205	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	322.43	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	251.88	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	70.55	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	189.23	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	14,005,480	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	61,725,663	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	621.05	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	9,287,803	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)	9,287,803	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/16/2018 8:40 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	1,714,391	2,837	604.30	340	205,462	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	15,717,130	13,204	1,190.33	1,699	2,022,371	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	9,711,729	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	21,227,365	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	8,023	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	761.97	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	6,113,285	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/16/2018 8:40 am

Title XIX | Hospital | Cost

	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	4,536,977	75,731,143	0.059909	6,113,285	366,241	90.00
91.00	Nursing School cost	0	75,731,143	0.000000	6,113,285	0	91.00
92.00	Allied health cost	0	75,731,143	0.000000	6,113,285	0	92.00
93.00	All other Medical Education	0	75,731,143	0.000000	6,113,285	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 26-0104 Component CCN: 26-S104	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/16/2018 8:40 am
	Title XIX	Subprovider - IPF	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,912	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,912	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.	365	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,547	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,078	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)	2,837	15.00
16.00	Nursery days (title V or XIX only)	340	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,708,945	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)	4,708,945	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	3,003,099	28.00
29.00	Private room charges (excluding swing-bed charges)	223,184	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	2,779,915	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.568029	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	611.46	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	611.37	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.09	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.14	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	51	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,708,894	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	958.65	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,992,075	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,992,075	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-0104 | Component CCN: 26-S104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/16/2018 8:40 am

Title XIX | Subprovider - IPF | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	180,958	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,173,033	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1

Component CCN: 26-S104 | Date/Time Prepared: 5/16/2018 8:40 am

Title XIX | Subprovider - IPF | Cost

	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	576,424	4,708,945	0.122410	0	0	90.00
91.00	Nursing School cost	0	4,708,945	0.000000	0	0	91.00
92.00	Allied health cost	0	4,708,945	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,708,945	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 26-0104 Component CCN: 26-5842	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/16/2018 8:40 am
	Title XIX	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	16,890	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	16,890	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)	16,890	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	11,826	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)	2,837	15.00
16.00	Nursery days (title V or XIX only)	340	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,947,637	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)	6,947,637	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,947,637	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-0104 | Component CCN: 26-5842 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/16/2018 8:40 am

Title XIX | Skilled Nursing Facility | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		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		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)	6,947,637	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	411.35	71.00
72.00	Program routine service cost (line 9 x line 71)	4,864,625	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	4,864,625	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	326,170	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	19.31	76.00
77.00	Program capital-related costs (line 9 x line 76)	228,360	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	4,636,265	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	4,636,265	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	228,360	83.00
84.00	Program inpatient ancillary services (see instructions)	0	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	228,360	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 26-0104 Component CCN: 26-5842	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/16/2018 8:40 am
	Title XIX	Skilled Nursing Facility	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/16/2018 8:40 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		52,974,331		30.00
31.00	03100	INTENSIVE CARE UNIT		16,555,140		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.214700	27,235,966	5,847,562	50.00
51.00	05100	RECOVERY ROOM	0.148783	2,835,822	421,922	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.340067	31,226	10,619	52.00
52.01	05201	PERINATAL CLINIC	0.299489	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.032526	4,527,469	147,260	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174250	6,308,846	1,099,316	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.176285	354,972	62,576	55.00
56.00	05600	RADIOISOTOPE	0.200890	1,647,280	330,922	56.00
57.00	05700	CT SCAN	0.028057	11,387,521	319,500	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.085396	2,995,411	255,796	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.109771	6,014,711	660,241	59.00
60.00	06000	LABORATORY	0.059293	25,951,398	1,538,736	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.318089	2,730,998	868,700	62.00
64.00	06400	INTRAVENOUS THERAPY	0.302662	41,374	12,522	64.00
65.00	06500	RESPIRATORY THERAPY	0.208345	6,859,874	1,429,220	65.00
66.00	06600	PHYSICAL THERAPY	0.425398	2,484,631	1,056,957	66.00
66.01	06601	CLINICAL NUTRITION	4.594674	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.424046	1,009,167	427,933	67.00
68.00	06800	SPEECH PATHOLOGY	0.236806	915,404	216,773	68.00
69.00	06900	ELECTROCARDIOLOGY	0.086936	8,471,937	736,516	69.00
69.01	06901	CARDIAC REHABILITATION	1.307674	54,016	70,635	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.105290	1,207,214	127,108	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.216296	53,716	11,619	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.887464	10,791,170	9,576,775	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.731176	10,518,002	7,690,511	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.160866	22,922,224	3,687,406	73.00
74.00	07400	RENAL DIALYSIS	0.364973	3,149,001	1,149,300	74.00
76.00	03330	ENDOSCOPY	0.157607	1,143,341	180,199	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.854426	890	760	90.00
91.00	09100	EMERGENCY	0.239564	5,274,177	1,263,503	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.198897	3,058,937	608,413	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		169,976,695	39,809,300	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)		169,976,695		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 26-0104 | Component CCN: 26-S104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/16/2018 8:40 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		2,729,241		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.214700	11,722	2,517	50.00
51.00	05100	RECOVERY ROOM	0.148783	1,140	170	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.340067	0	0	52.00
52.01	05201	PERINATAL CLINIC	0.299489	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.032526	8,556	278	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174250	13,103	2,283	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.176285	356	63	55.00
56.00	05600	RADIOISOTOPE	0.200890	0	0	56.00
57.00	05700	CT SCAN	0.028057	24,900	699	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.085396	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.109771	0	0	59.00
60.00	06000	LABORATORY	0.059293	363,721	21,566	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.318089	2,676	851	62.00
64.00	06400	INTRAVENOUS THERAPY	0.302662	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.208345	5,844	1,218	65.00
66.00	06600	PHYSICAL THERAPY	0.425398	513	218	66.00
66.01	06601	CLINICAL NUTRITION	4.594674	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.424046	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.236806	1,315	311	68.00
69.00	06900	ELECTROCARDIOLOGY	0.086936	6,706	583	69.00
69.01	06901	CARDIAC REHABILITATION	1.307674	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.105290	1,093	115	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.216296	29,957	6,480	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.887464	1,267	1,124	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.731176	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.160866	590,657	95,017	73.00
74.00	07400	RENAL DIALYSIS	0.364973	36,456	13,305	74.00
76.00	03330	ENDOSCOPY	0.157607	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.854426	0	0	90.00
91.00	09100	EMERGENCY	0.239564	167,912	40,226	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.198897	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,267,894	187,024	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)		1,267,894		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 26-0104	Period: From 01/01/2017	Worksheet D-3
	Component CCN: 26-5842	To 12/31/2017	Date/Time Prepared: 5/16/2018 8:40 am
	Title XVIII	Skilled Nursing Facility	PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.214550	0	0	50.00
51.00	05100	RECOVERY ROOM	0.148783	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.340067	0	0	52.00
52.01	05201	PERINATAL CLINIC	0.299489	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.031519	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174250	4,954	863	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.176285	0	0	55.00
56.00	05600	RADIOISOTOPE	0.200890	0	0	56.00
57.00	05700	CT SCAN	0.028057	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.085396	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.109771	0	0	59.00
60.00	06000	LABORATORY	0.059293	5,841	346	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.318089	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.302662	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.207933	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.425398	342,272	145,602	66.00
66.01	06601	CLINICAL NUTRITION	4.594674	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.424046	351,542	149,070	67.00
68.00	06800	SPEECH PATHOLOGY	0.236806	127,779	30,259	68.00
69.00	06900	ELECTROCARDIOLOGY	0.086936	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	1.306879	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.105290	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.216296	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.887464	13,709	12,166	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.731176	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.160866	122,350	19,682	73.00
74.00	07400	RENAL DIALYSIS	0.364973	0	0	74.00
76.00	03330	ENDOSCOPY	0.157607	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.853253	0	0	90.00
91.00	09100	EMERGENCY	0.239564	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.198897	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		968,447	357,988	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)		968,447		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/16/2018 8:40 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		28,234,654		30.00
31.00	03100	INTENSIVE CARE UNIT		5,095,773		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY		583,847		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.214550	2,530,165	542,847	50.00
51.00	05100	RECOVERY ROOM	0.148783	365,677	54,407	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.340067	334,084	113,611	52.00
52.01	05201	PERINATAL CLINIC	0.299489	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.031519	670,645	21,138	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174250	2,442,306	425,572	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.176285	114,791	20,236	55.00
56.00	05600	RADIOISOTOPE	0.200890	428,170	86,015	56.00
57.00	05700	CT SCAN	0.028057	3,727,528	104,583	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.085396	912,336	77,910	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.109771	1,679,002	184,306	59.00
60.00	06000	LABORATORY	0.059293	10,124,399	600,306	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.318089	1,190,895	378,811	62.00
64.00	06400	INTRAVENOUS THERAPY	0.302662	72,562	21,962	64.00
65.00	06500	RESPIRATORY THERAPY	0.207933	2,868,908	596,541	65.00
66.00	06600	PHYSICAL THERAPY	0.425398	410,225	174,509	66.00
66.01	06601	CLINICAL NUTRITION	4.594674	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.424046	187,620	79,560	67.00
68.00	06800	SPEECH PATHOLOGY	0.236806	189,072	44,773	68.00
69.00	06900	ELECTROCARDIOLOGY	0.086936	2,385,356	207,373	69.00
69.01	06901	CARDIAC REHABILITATION	1.306879	31,063	40,596	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.105290	618,494	65,121	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.216296	63,013	13,629	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.887464	2,413,836	2,142,193	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.731176	818,925	598,778	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.160866	9,061,501	1,457,687	73.00
74.00	07400	RENAL DIALYSIS	0.364973	557,766	203,570	74.00
76.00	03330	ENDOSCOPY	0.157607	332,917	52,470	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.853253	981	837	90.00
91.00	09100	EMERGENCY	0.239564	4,809,517	1,152,187	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.198897	1,257,943	250,201	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		50,599,697	9,711,729	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)		50,599,697		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 26-0104 | Component CCN: 26-S104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/16/2018 8:40 am

Title XIX | Subprovider - IPF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		3,003,099		40.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.214550	0	0	50.00
51.00	05100	RECOVERY ROOM	0.148783	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.340067	0	0	52.00
52.01	05201	PERINATAL CLINIC	0.299489	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.031519	391	12	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174250	13,096	2,282	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.176285	0	0	55.00
56.00	05600	RADIOISOTOPE	0.200890	2,917	586	56.00
57.00	05700	CT SCAN	0.028057	31,620	887	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.085396	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.109771	0	0	59.00
60.00	06000	LABORATORY	0.059293	460,533	27,306	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.318089	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.302662	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.207933	2,052	427	65.00
66.00	06600	PHYSICAL THERAPY	0.425398	0	0	66.00
66.01	06601	CLINICAL NUTRITION	4.594674	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.424046	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.236806	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.086936	11,957	1,039	69.00
69.01	06901	CARDIAC REHABILITATION	1.306879	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.105290	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.216296	1,033	223	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.887464	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.731176	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.160866	553,882	89,101	73.00
74.00	07400	RENAL DIALYSIS	0.364973	0	0	74.00
76.00	03330	ENDOSCOPY	0.157607	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.853253	0	0	90.00
91.00	09100	EMERGENCY	0.239564	241,419	57,835	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.198897	6,337	1,260	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,325,237	180,958	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)		1,325,237		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 26-0104	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/16/2018 8:40 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	42,571,382	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	14,725,994	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	660,616	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	38,376,309	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	408.02	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	14.22	11.00
12.00	Current year allowable FTE (see instructions)	14.22	12.00
13.00	Total allowable FTE count for the prior year.	14.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	11.86	14.00
15.00	Sum of lines 12 through 14 divided by 3.	13.36	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	13.36	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.032743	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.029645	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.029645	21.00
22.00	IME payment adjustment (see instructions)	920,654	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	616,631	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	920,654	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	616,631	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	5.81	30.00
31.00	Percentage of Medicaid patient days (see instructions)	27.17	31.00
32.00	Sum of lines 30 and 31	32.98	32.00
33.00	Allowable disproportionate share percentage (see instructions)	16.43	33.00
34.00	Disproportionate share adjustment (see instructions)	2,353,490	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 26-0104	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/16/2018 8:40 am
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	5,977,483,147	6,766,695,164	35.00
35.01	Factor 3 (see instructions)	0.000821604	0.000828138	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	4,911,124	5,603,757	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	3,673,251	1,412,455	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	5,085,706		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	66,317,842		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	66,934,473	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	5,010,247	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	468,516	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	4,143	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	31,856	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	8,906	58.00
59.00	Total (sum of amounts on lines 49 through 58)	72,458,141	59.00
60.00	Primary payer payments	98,858	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	72,359,283	61.00
62.00	Deductibles billed to program beneficiaries	5,692,792	62.00
63.00	Coinsurance billed to program beneficiaries	493,430	63.00
64.00	Allowable bad debts (see instructions)	2,226,374	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	1,447,143	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,574,125	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	67,620,204	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	72,598	70.93
70.94	HRR adjustment amount (see instructions)	-242,621	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 26-0104	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/16/2018 8:40 am
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		717,788	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		66,732,393	71.00
71.01	Sequestration adjustment (see instructions)		1,334,648	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		65,311,819	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		85,926	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/16/2018 8:40 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	42,571,382	0	42,571,382		42,571,382	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	14,725,994	0		14,725,994	14,725,994	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	660,616	0	0	0	0	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	38,376,309	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.029645	0.029645	0.029645	0.029645		5.00
6.00	IME payment adjustment (see instructions)	22.00	920,654	0	684,037	236,617	920,654	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	616,631	0	616,631	0	616,631	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	920,654	0	684,037	236,617	920,654	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	616,631	0	616,631	0	616,631	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1643	0.1643	0.1643	0.1643		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	2,353,490	0	1,748,620	604,870	2,353,490	11.00
11.01	Uncompensated care payments	36.00	5,085,706	0	3,673,251	1,412,455	5,085,706	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	66,317,842	0	49,337,906	16,979,936	66,317,842	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	66,934,473	0	49,954,537	16,979,936	66,934,473	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	5,010,247	0	3,747,390	1,262,857	5,010,247	16.00
17.00	Special add-on payments for new technologies	54.00	4,143	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/16/2018 8:40 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	53,701,927	18,242,793	71,944,720	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	4,609,882	0	3,447,938	1,161,944	4,609,882	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	21,894	0	16,376	5,518	21,894	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0130	0.0130	0.0130	0.0130		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	59,928	0	44,823	15,105	59,928	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0691	0.0691	0.0691	0.0691		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	318,543	0	238,253	80,290	318,543	25.00
26.00	Total prospective capital payments (see instructions)	12.00	5,010,247	0	3,747,390	1,262,857	5,010,247	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		N					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/16/2018 8:40 am

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	42,571,382	42,571,382		42,571,382	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	14,725,994		14,725,994	14,725,994	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	660,616	526,854	133,762	660,616	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	38,376,309	28,841,900	9,534,409	38,376,309	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.029645	0.029645	0.029645		5.00
6.00	IME payment adjustment (see instructions)	22.00	920,654	684,037	236,617	920,654	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	616,631	463,432	153,199	616,631	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	920,654	684,037	236,617	920,654	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	616,631	463,432	153,199	616,631	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1643	0.1643	0.1643		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	2,353,490	1,748,620	604,870	2,353,490	11.00
11.01	Uncompensated care payments	36.00	5,085,706	3,673,251	1,412,455	5,085,706	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	66,317,842	49,204,144	17,113,698	66,317,842	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	66,934,473	49,667,576	17,266,897	66,934,473	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	5,010,247	3,716,660	1,293,587	5,010,247	16.00
17.00	Special add-on payments for new technologies	54.00	4,143	4,143	0	4,143	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			53,388,379	18,560,484	71,948,863	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/16/2018 8:40 am

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	4,609,882	3,419,828	1,190,054	4,609,882	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	21,894	16,065	5,829	21,894	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0130	0.0130	0.0130		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	59,928	44,457	15,471	59,928	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0691	0.0691	0.0691		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	318,543	236,310	82,233	318,543	25.00
26.00	Total prospective capital payments (see instructions)	12.00	5,010,247	3,716,660	1,293,587	5,010,247	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	72,598	72,598	0	72,598	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-242,621	-166,047	-76,574	-242,621	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		532,949	184,839	717,788	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 26-0104	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/16/2018 8:40 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	86,094	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	39,806,640	2.00
3.00	OPPS payments	41,337,467	3.00
4.00	Outlier payment (see instructions)	49,467	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	8,205	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	86,094	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	535,193	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)	535,193	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	535,193	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	449,099	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)	86,094	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)	41,395,139	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	7,928,923	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)	33,552,310	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	270,227	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)	33,822,537	30.00
31.00	Primary payer payments	22,902	31.00
32.00	Subtotal (line 30 minus line 31)	33,799,635	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	739,459	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	480,648	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	299,981	36.00
37.00	Subtotal (see instructions)	34,280,283	37.00
38.00	MSP-LCC reconciliation amount from PS&R	555	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)	34,279,728	40.00
40.01	Sequestration adjustment (see instructions)	685,595	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	33,565,484	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	28,649	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 26-0104 Component CCN: 26-S104	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/16/2018 8:40 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	550,780	2.00
3.00	OPPS payments	575,141	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	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)	575,141	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	115,906	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)	459,235	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)	459,235	30.00
31.00	Primary payer payments	510	31.00
32.00	Subtotal (line 30 minus line 31)	458,725	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	458,725	37.00
38.00	MSP-LCC reconciliation amount from PS&R	76	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)	458,649	40.00
40.01	Sequestration adjustment (see instructions)	9,173	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	449,465	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	11	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/16/2018 8:40 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		63,573,040		32,863,359	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		1,605,879		641,525	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	06/23/2017	132,900	06/23/2017	60,600	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)		132,900		60,600	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)		65,311,819		33,565,484	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		85,926		28,649	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		65,397,745		33,594,133	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 26-0104 | Component CCN: 26-S104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/16/2018 8:40 am

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,342,688		449,465	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		78,911		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)		1,421,599		449,465	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		18,223		11	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,439,822		449,476	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 26-0104 | Component CCN: 26-5842 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/16/2018 8:40 am

Title XVIII | Skilled Nursing Facility | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,376,737		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)		1,376,737		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)		1,376,737		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: 26-0104	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/16/2018 8:40 am
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 26-0104 Component CCN: 26-S104	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part II Date/Time Prepared: 5/16/2018 8:40 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1,428,158	1.00
2.00	Net IPF PPS Outlier Payments	100,946	2.00
3.00	Net IPF PPS ECT Payments	9,008	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	13.457534	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1,538,112	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	1,538,112	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	1,538,112	18.00
19.00	Deductibles	148,624	19.00
20.00	Subtotal (line 18 minus line 19)	1,389,488	20.00
21.00	Coinsurance	19,383	21.00
22.00	Subtotal (line 20 minus line 21)	1,370,105	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	128,884	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	83,775	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	66,163	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,453,880	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	15,326	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	1,469,206	31.00
31.01	Sequestration adjustment (see instructions)	29,384	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	1,421,599	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	18,223	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	100,946	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 26-0104 Component CCN: 26-5842	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part VI Date/Time Prepared: 5/16/2018 8:40 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,520,642	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,520,642	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	115,808	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	1,404,834	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	1,404,834	15.00
15.01	Sequestration adjustment (see instructions)	28,097	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
16.00	Interim payments	1,376,737	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-4 | Date/Time Prepared: 5/16/2018 8:40 am

Title XVIII | Hospital | PPS

				1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.00	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	0.00	0.00	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		14.22		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		14.22		10.01
11.00	Total weighted FTE count	0.00	14.22		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	14.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	11.86		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	13.36		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.00	13.36		17.00
18.00	Per resident amount	116,422.52	116,422.52		18.00
19.00	Approved amount for resident costs	0	1,555,405	1,555,405	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			103,653.85	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			1,555,405	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions)	34,638	20,426		26.00
27.00	Total Inpatient Days (see instructions)	109,859	109,859		27.00
28.00	Ratio of inpatient days to total inpatient days	0.315295	0.185929		28.00
29.00	Program direct GME amount	490,411	289,195		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		40,863		30.00
31.00	Net Program direct GME amount			738,743	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 26-0104	Period: From 01/01/2017 To 12/31/2017	Worksheet E-4 Date/Time Prepared: 5/16/2018 8:40 am
	Title XVIII	Hospital	PPS

		1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)		
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)	0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)	5,883,278	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)	0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)	0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)	0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
	Part A Reasonable Cost		
37.00	Reasonable cost (see instructions)	70,193,063	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)	0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)	0	39.00
40.00	Primary payer payments (see instructions)	98,858	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	70,094,205	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	40,451,719	42.00
43.00	Primary payer payments (see instructions)	23,412	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	40,428,307	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	110,522,512	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.634207	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.365793	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	738,743	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	468,516	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	270,227	50.00

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

Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G | Date/Time Prepared: 5/16/2018 8:40 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	68,862,412	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	57,109,508	0	0	0	4.00
5.00	Other receivable	3,127,165	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	6,566,863	0	0	0	7.00
8.00	Prepaid expenses	801,023	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)	136,466,971	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	9,615,392	0	0	0	12.00
13.00	Land improvements	2,865,359	0	0	0	13.00
14.00	Accumulated depreciation	-2,100,704	0	0	0	14.00
15.00	Buildings	100,963,020	0	0	0	15.00
16.00	Accumulated depreciation	-44,555,165	0	0	0	16.00
17.00	Leasehold improvements	2,942,731	0	0	0	17.00
18.00	Accumulated depreciation	-1,298,833	0	0	0	18.00
19.00	Fixed equipment	3,686,594	0	0	0	19.00
20.00	Accumulated depreciation	-1,753,367	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	82,949,959	0	0	0	23.00
24.00	Accumulated depreciation	-57,219,748	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)	96,095,238	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	2,840,012	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	13,274,674	1,831,606	138,956	0	34.00
35.00	Total other assets (sum of lines 31-34)	16,114,686	1,831,606	138,956	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	248,676,895	1,831,606	138,956	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	22,290,963	0	0	0	37.00
38.00	Salaries, wages, and fees payable	9,015,792	0	0	0	38.00
39.00	Payroll taxes payable	1,558,504	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,688,369	0	0	0	40.00
41.00	Deferred income	-103,050	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	19,055,335	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	53,505,913	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	21,178,001	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	21,178,001	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	74,683,914	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	173,992,981				52.00
53.00	Specific purpose fund		1,831,606			53.00
54.00	Donor created - endowment fund balance - restricted			138,956		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)	173,992,981	1,831,606	138,956	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	248,676,895	1,831,606	138,956	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-1 | Date/Time Prepared: 5/16/2018 8:40 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		136,495,641		1,588,923		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		43,453,035				2.00
3.00	Total (sum of line 1 and line 2)		179,948,676		1,588,923		3.00
4.00	CREDIT ADJUSTMENTS	150		242,683		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		150		242,683		10.00
11.00	Subtotal (line 3 plus line 10)		179,948,826		1,831,606		11.00
12.00	DEBIT ADJUSTMENTS	150		0		0	12.00
13.00	CORPORATE OFFICE	5,950,905		0		0	13.00
14.00		0		0		0	14.00
15.00	TRANSFER TO OTHER RELATED ORG	4,790		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		5,955,845		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		173,992,981		1,831,606		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	138,956		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)	138,956		0		3.00
4.00	CREDIT ADJUSTMENTS		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)	138,956		0		11.00
12.00	DEBIT ADJUSTMENTS		0			12.00
13.00	CORPORATE OFFICE		0			13.00
14.00			0			14.00
15.00	TRANSFER TO OTHER RELATED ORG		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)	138,956		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/16/2018 8:40 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	179,949,357		179,949,357	1.00
2.00	SUBPROVIDER - IPF	7,746,245		7,746,245	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	4,253,608		4,253,608	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	191,949,210		191,949,210	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	39,628,061		39,628,061	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	39,628,061		39,628,061	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	231,577,271		231,577,271	17.00
18.00	Ancillary services	483,247,938	632,406,795	1,115,654,733	18.00
19.00	Outpatient services	39,957,974	94,386,627	134,344,601	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NON-REIMBURSABLE PRO FEES	4,012,991	11,239,110	15,252,101	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	758,796,174	738,032,532	1,496,828,706	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		410,194,651		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)		410,194,651		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 26-0104 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-3 | Date/Time Prepared: 5/16/2018 8:40 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,496,828,706	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,070,258,439	2.00
3.00	Net patient revenues (line 1 minus line 2)	426,570,267	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	410,194,651	4.00
5.00	Net income from service to patients (line 3 minus line 4)	16,375,616	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	316,909	6.00
7.00	Income from investments	450,098	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	22,323	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	1,790,242	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	2,668	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	423,627	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	24,071,552	24.00
25.00	Total other income (sum of lines 6-24)	27,077,419	25.00
26.00	Total (line 5 plus line 25)	43,453,035	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)	43,453,035	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 26-0104	Period: From 01/01/2017 To 12/31/2017	Worksheet L Parts I-III Date/Time Prepared: 5/16/2018 8:40 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	4,609,882	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	21,894	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	291.25	3.00
4.00	Number of interns & residents (see instructions)	13.36	4.00
5.00	Indirect medical education percentage (see instructions)	1.30	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	59,928	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	5.81	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	27.17	8.00
9.00	Sum of lines 7 and 8	32.98	9.00
10.00	Allowable disproportionate share percentage (see instructions)	6.91	10.00
11.00	Disproportionate share adjustment (see instructions)	318,543	11.00
12.00	Total prospective capital payments (see instructions)	5,010,247	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00