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 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/28/2019 12:59 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/28/2019 Time: 12:59 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 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[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 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	442,294	99,302	0	0	1.00
2.00	Subprovider - IPF	0	-10,293	0		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	432,001	99,302	0	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 12:59 pm

	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)	01/01/2018	12/31/2018	20.00
21.00	Type of Control (see instructions)	1		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	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	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/28/2019 12:59 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
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.	16,978	2,878	523	727	9,665	331	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

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	Y	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 12:59 pm

		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
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/28/2019 12:59 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	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 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 12:59 pm

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/28/2019 12:59 pm

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

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	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 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/28/2019 12:59 pm

	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)	09/30/2018	12/28/2018	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 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 5/28/2019 12:59 pm

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	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	04/12/2019	Y	04/12/2019
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	

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		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.	BRIAN		SCHMEIDLER		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.	314-989-3524		BRIAN.SCHMEIDLER@SSMHEALTH.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 26-0104	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/28/2019 12:59 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REGIONAL DIR- GOVERNMENT REIMBURSEME		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 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/28/2019 12:59 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	382	139,430	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)		382	139,430	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	51	18,615	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)		433	158,045	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	22	8,030		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

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	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)	27,233	15,100	88,039			1.00
2.00	HMO and other (see instructions)	20,575	13,793				2.00
3.00	HMO IPF Subprovider	0	253				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)	27,233	15,100	88,039			7.00
8.00	INTENSIVE CARE UNIT	1,953	1,724	14,961			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		154	2,281			13.00
14.00	Total (see instructions)	29,186	16,978	105,281	15.00	1,728.70	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,803	1,667	6,331	0.00	108.61	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	3,466	12,046	16,980	0.00	61.72	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			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	1,899.03	27.00
28.00	Observation Bed Days		509	7,947			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			1,513			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	331	422			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 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/28/2019 12:59 pm

	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	6,048	3,460	25,205	1.00
2.00	HMO and other (see instructions)			4,150	2,865		2.00
3.00	HMO IPF Subprovider				57		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	6,048	3,460	25,205	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	418	285	1,140	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 01/01/2018 To 12/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 5/28/2019 12:59 pm

		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	127,904,815	0	127,904,815	3,381,065.94	37.83	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		315,512	0	315,512	2,794.38	112.91	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		4,206,666	0	4,206,666	21,907.91	192.02	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	974,556	0	974,556	32,856.97	29.66	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	2,461,446	0	2,461,446	128,378.45	19.17	9.00
10.00	Excluded area salaries (see instructions)		7,659,444	-5,176,111	2,483,333	53,931.39	46.05	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		7,264,532	0	7,264,532	135,810.83	53.49	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		6,858,512	0	6,858,512	67,573.15	101.50	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	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)		45,724,819	43,739,783	89,464,602			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		612,915	580,738	1,193,653			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		18,900	18,900	37,800			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		179,171	179,171	358,342			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		69,983	69,983	139,966			25.00
25.50	Home office wage-related (core)		4,871,332	0	4,871,332			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	325,918	0	325,918	11,068.31	29.45	26.00
27.00	Administrative & General	5.00	12,502,256	-387,922	12,114,334	324,917.67	37.28	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 5/28/2019 12:59 pm

		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.)		936,017	0	936,017	11,044.51	84.75	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,729,679	0	1,729,679	50,847.78	34.02	30.00
31.00	Laundry & Linen Service	8.00	136,564	0	136,564	8,385.95	16.28	31.00
32.00	Housekeeping	9.00	2,744,066	0	2,744,066	168,673.48	16.27	32.00
33.00	Housekeeping under contract (see instructions)		395,711	0	395,711	13,831.00	28.61	33.00
34.00	Dietary	10.00	2,513,287	0	2,513,287	152,299.71	16.50	34.00
35.00	Dietary under contract (see instructions)		607,131	0	607,131	21,118.00	28.75	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	2,425,110	0	2,425,110	62,284.45	38.94	38.00
39.00	Central Services and Supply	14.00	316,211	387,922	704,133	35,489.87	19.84	39.00
40.00	Pharmacy	15.00	5,102,036	-83,665	5,018,371	95,863.91	52.35	40.00
41.00	Medical Records & Medical Records Library	16.00	386,523	0	386,523	18,251.27	21.18	41.00
42.00	Social Service	17.00	466,778	0	466,778	9,757.22	47.84	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 01/01/2018 To 12/31/2018 | Worksheet S-3 Part III Date/Time Prepared: 5/28/2019 12:59 pm

		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)		124,662,452	0	124,662,452	3,372,294.57	36.97	1.00
2.00	Excluded area salaries (see instructions)		10,120,890	-5,176,111	4,944,779	182,309.84	27.12	2.00
3.00	Subtotal salaries (line 1 minus line 2)		114,541,562	5,176,111	119,717,673	3,189,984.73	37.53	3.00
4.00	Subtotal other wages & related costs (see inst.)		14,123,044	0	14,123,044	203,383.98	69.44	4.00
5.00	Subtotal wage-related costs (see inst.)		50,615,051	43,758,683	94,373,734	0.00	78.83	5.00
6.00	Total (sum of lines 3 thru 5)		179,279,657	48,934,794	228,214,451	3,393,368.71	67.25	6.00
7.00	Total overhead cost (see instructions)		30,587,287	-83,665	30,503,622	983,833.13	31.00	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part IV Date/Time Prepared: 5/28/2019 12:59 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	2,040,834	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	7,438,427	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	16,787,715	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	5,933,216	9.00
10.00	Dental, Hearing and Vision Plan	1,217,219	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	383,024	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)	402,773	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	2,595,672	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	8,419,669	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	213,270	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	820,324	22.00
23.00	Tuition Reimbursement	353,644	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	46,605,787	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 01/01/2018 To 12/31/2018 | Worksheet S-3 Part V Date/Time Prepared: 5/28/2019 12:59 pm

	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	8,178,158	46,605,787	1.00
2.00	Hospital	7,264,532	46,448,758	2.00
3.00	Subprovider - IPF	153,739	157,029	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	759,887	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-7 | Date/Time Prepared: 5/28/2019 12:59 pm

		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	1	0	1	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	702	0	702	12.00
13.00		RUB	985	0	985	13.00
14.00		RUA	903	0	903	14.00
15.00		RVC	230	0	230	15.00
16.00		RVB	220	0	220	16.00
17.00		RVA	273	0	273	17.00
18.00		RHC	19	0	19	18.00
19.00		RHB	23	0	23	19.00
20.00		RHA	3	0	3	20.00
21.00		RMC	12	0	12	21.00
22.00		RMB	0	0	0	22.00
23.00		RMA	3	0	3	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	1	0	1	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	0	0	0	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	4	0	4	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	9	0	9	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	5	0	5	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	0	0	0	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	9	0	9	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	30	0	30	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	3	0	3	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 01/01/2018 To 12/31/2018 | Worksheet S-7 | Date/Time Prepared: 5/28/2019 12:59 pm

		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	5	0	5	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	9	0	9	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	2	0	2	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		3,466	0	3,466	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)	4,303,671			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-10 | Date/Time Prepared: 5/28/2019 12:59 pm

		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)	0.237488	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	59,477,121	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	626,802	5.00
6.00	Medicaid charges	223,364,048	6.00
7.00	Medicaid cost (line 1 times line 6)	53,046,281	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	50,360,654	7,512,799	57,873,453	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	11,960,051	7,512,799	19,472,850	21.00
22.00	Payments received from patients for amounts previously written off as charity care	52,903	675,887	728,790	22.00
23.00	Cost of charity care (line 21 minus line 22)	11,907,148	6,836,912	18,744,060	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)	32,992,892	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	2,118,287	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	3,258,902	27.01
28.00	Non-Medicare bad debt expense (see instructions)	29,733,990	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	8,202,081	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	26,946,141	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	26,946,141	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/28/2019 12:59 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		8,169,616	8,169,616	-52,781	8,116,835	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		6,328,907	6,328,907	0	6,328,907	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	325,918	33,164,921	33,490,839	52,781	33,543,620	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,502,256	79,888,717	92,390,973	-1,229,326	91,161,647	5.00
7.00	00700	OPERATION OF PLANT	1,729,679	9,247,516	10,977,195	0	10,977,195	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	136,564	937,012	1,073,576	0	1,073,576	8.00
9.00	00900	HOUSEKEEPING	2,744,066	1,528,127	4,272,193	0	4,272,193	9.00
10.00	01000	DIETARY	2,513,287	4,917,475	7,430,762	0	7,430,762	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,425,110	763,874	3,188,984	0	3,188,984	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	316,211	1,091,434	1,407,645	1,229,326	2,636,971	14.00
15.00	01500	PHARMACY	5,102,036	38,002,440	43,104,476	-36,526,415	6,578,061	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	386,523	193,643	580,166	0	580,166	16.00
17.00	01700	SOCIAL SERVICE	466,778	198,588	665,366	0	665,366	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	974,556	72,220	1,046,776	-72,220	974,556	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	72,220	72,220	22.00
23.00	02300	PHARMACY RESIDENCY PROGRAM	290,264	20,099	310,363	83,665	394,028	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	32,769,355	4,673,754	37,443,109	3,632,220	41,075,329	30.00
31.00	03100	INTENSIVE CARE UNIT	7,632,349	3,702,409	11,334,758	-186,507	11,148,251	31.00
40.00	04000	SUBPROVIDER - IPF	7,160,299	2,323,146	9,483,445	-7,400,892	2,082,553	40.00
43.00	04300	NURSERY	297,566	9	297,575	1,163,790	1,461,365	43.00
44.00	04400	SKILLED NURSING FACILITY	2,461,446	2,071,271	4,532,717	-265,565	4,267,152	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,448,350	27,601,407	36,049,757	-22,663,296	13,386,461	50.00
51.00	05100	RECOVERY ROOM	1,021,247	58,196	1,079,443	-37,429	1,042,014	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,393,606	465,998	3,859,604	-1,945,684	1,913,920	52.00
52.01	05201	PERINATAL CLINIC	622,431	718,917	1,341,348	-11,429	1,329,919	52.01
53.00	05300	ANESTHESIOLOGY	76,641	3,922,967	3,999,608	-675,296	3,324,312	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,480,826	8,118,287	11,599,113	-4,488,318	7,110,795	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,150,671	833,671	2,984,342	-19,452	2,964,890	55.00
56.00	05600	RADIOISOTOPE	297,887	835,224	1,133,111	-7,568	1,125,543	56.00
57.00	05700	CT SCAN	841,601	627,919	1,469,520	-220,126	1,249,394	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	349,703	146,912	496,615	-19,501	477,114	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,318,989	12,618,378	13,937,367	-12,203,700	1,733,667	59.00
60.00	06000	LABORATORY	1,979,117	2,892,347	4,871,464	-24,752	4,846,712	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	433,022	1,402,703	1,835,725	1,102,104	2,937,829	62.00
64.00	06400	INTRAVENOUS THERAPY	1,849,076	790,953	2,640,029	-298,961	2,341,068	64.00
65.00	06500	RESPIRATORY THERAPY	2,276,044	1,376,092	3,652,136	-344,600	3,307,536	65.00
66.00	06600	PHYSICAL THERAPY	0	2,418,406	2,418,406	-15,527	2,402,879	66.00
66.01	06601	CLINICAL NUTRITION	711,686	3,193	714,879	-85	714,794	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	915,399	915,399	-18,786	896,613	67.00
68.00	06800	SPEECH PATHOLOGY	0	449,748	449,748	-633	449,115	68.00
69.00	06900	ELECTROCARDIOLOGY	2,733,833	1,868,699	4,602,532	-847,649	3,754,883	69.00
69.01	06901	CARDIAC REHABILITATION	313,564	10,387	323,951	-4,105	319,846	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	306,713	149,751	456,464	-65,539	390,925	70.00
70.01	07001	ELECTROSHOCK THERAPY	91,911	17,135	109,046	-14,187	94,859	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	26,680,322	26,680,322	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	21,583,048	21,583,048	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	35,554,963	35,554,963	73.00
74.00	07400	RENAL DIALYSIS	0	1,882,441	1,882,441	-41,984	1,840,457	74.00
76.00	03330	ENDOSCOPY	981,821	1,026,428	2,008,249	-544,462	1,463,787	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,433,805	5,301,592	10,735,397	393,682	11,129,079	90.00
91.00	09100	EMERGENCY	8,349,127	3,942,258	12,291,385	-1,301,266	10,990,119	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)	127,695,934	277,690,586	405,386,520	80	405,386,600	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	56,101	82,920	139,021	0	139,021	190.00
191.00	19100	RESEARCH	89,842	7	89,849	-7	89,842	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	NON-REIMBURSABLE	62,938	11,215	74,153	-73	74,080	194.00
194.01	07950	OTHER	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	0	12,419,573	12,419,573	0	12,419,573	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	127,904,815	290,204,301	418,109,116	0	418,109,116	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/28/2019 12:59 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	494,002	8,610,837		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,221,060	7,549,967		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-7,919,702	25,623,918		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-8,588,468	82,573,179		5.00
7.00	00700	OPERATION OF PLANT	-1,527,175	9,450,020		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,073,576		8.00
9.00	00900	HOUSEKEEPING	0	4,272,193		9.00
10.00	01000	DIETARY	-1,754,653	5,676,109		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	-3,564	3,185,420		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,636,971		14.00
15.00	01500	PHARMACY	-30,084	6,547,977		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,852	577,314		16.00
17.00	01700	SOCIAL SERVICE	-87,578	577,788		17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	-58	974,498		21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	72,220		22.00
23.00	02300	PHARMACY RESIDENCY PROGRAM	-12,500	381,528		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-3,375,885	37,699,444		30.00
31.00	03100	INTENSIVE CARE UNIT	-2,055,989	9,092,262		31.00
40.00	04000	SUBPROVIDER - IPF	-1,328,203	754,350		40.00
43.00	04300	NURSERY	0	1,461,365		43.00
44.00	04400	SKILLED NURSING FACILITY	-122,740	4,144,412		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-21,350	13,365,111		50.00
51.00	05100	RECOVERY ROOM	-22	1,041,992		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,913,920		52.00
52.01	05201	PERINATAL CLINIC	-611,678	718,241		52.01
53.00	05300	ANESTHESIOLOGY	-2,667,606	656,706		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-517,219	6,593,576		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-31,898	2,932,992		55.00
56.00	05600	RADIOISOTOPE	-2,527	1,123,016		56.00
57.00	05700	CT SCAN	-54,893	1,194,501		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-24,519	452,595		58.00
59.00	05900	CARDIAC CATHETERIZATION	-8,809	1,724,858		59.00
60.00	06000	LABORATORY	-1,873,860	2,972,852		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	-74,297	2,863,532		62.00
64.00	06400	INTRAVENOUS THERAPY	-85,986	2,255,082		64.00
65.00	06500	RESPIRATORY THERAPY	-12,710	3,294,826		65.00
66.00	06600	PHYSICAL THERAPY	0	2,402,879		66.00
66.01	06601	CLINICAL NUTRITION	-70,888	643,906		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	896,613		67.00
68.00	06800	SPEECH PATHOLOGY	0	449,115		68.00
69.00	06900	ELECTROCARDIOLOGY	-357,836	3,397,047		69.00
69.01	06901	CARDIAC REHABILITATION	-3,313	316,533		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	-3,887	387,038		70.00
70.01	07001	ELECTROSHOCK THERAPY	0	94,859		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-1,231,836	25,448,486		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	21,583,048		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	35,554,963		73.00
74.00	07400	RENAL DIALYSIS	-794	1,839,663		74.00
76.00	03330	ENDOSCOPY	-1,049	1,462,738		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-2,532,156	8,596,923		90.00
91.00	09100	EMERGENCY	-1,495,395	9,494,724		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)	-36,778,917	368,607,683		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	139,021		190.00
191.00	19100	RESEARCH	0	89,842		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07951	NON-REIMBURSABLE	0	74,080		194.00
194.01	07950	OTHER	0	0		194.01
194.02	07952	OTHER NONREIMBURSABLE	0	0		194.02
194.03	07953	RETAIL PHARMACY	0	12,419,573		194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-36,778,917	381,330,199		200.00

RECLASSIFICATIONS | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/28/2019 12:59 pm

		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	1,102,153		1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	35,554,963		2.00
	0		0	36,657,116		
	B - NURSERY & L&D					
1.00	NURSERY	43.00	1,251,250	209,681		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	2,749,479	460,751		2.00
3.00	ADULTS & PEDIATRICS	30.00	635,176	139,410		3.00
4.00	INTENSIVE CARE UNIT	31.00	1,352,239	350,426		4.00
5.00	SUBPROVIDER - IPF	40.00	337,268	245,049		5.00
	0		6,325,412	1,405,317		
	C - CENTRAL SUPPLY					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	26,680,322		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	21,583,048		2.00
3.00		0.00	0	0		3.00
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
33.00		0.00	0	0		33.00
34.00		0.00	0	0		34.00
	0		0	48,263,370		
	D - BHM - DEPT					
1.00	ADULTS & PEDIATRICS	30.00	1,566,266	1,093,129		1.00
	0		1,566,266	1,093,129		
	E - BHM - ADMIN					
1.00	ADULTS & PEDIATRICS	30.00	3,307,464	903,065		1.00
2.00	CLINIC	90.00	381,419	104,142		2.00
	0		3,688,883	1,007,207		
	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	387,922	841,404		1.00
	0		387,922	841,404		
	H - RESIDENCY ANCILLARY					
1.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	0	72,220		1.00
	0		0	72,220		
	I - PHARMACY RESIDENCY					
1.00	PHARMACY RESIDENCY PROGRAM	23.00	83,665	0		1.00
	0		83,665	0		
500.00	Grand Total: Increases		12,052,148	89,392,544		500.00

RECLASSIFICATIONS | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/28/2019 12:59 pm

		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	36,442,750	0		1.00
2.00	SKILLED NURSING FACILITY	44.00	0	214,366	0		2.00
	0		0	36,657,116			
	B - NURSERY & L&D						
1.00	ADULTS & PEDIATRICS	30.00	1,214,103	326,567	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	330,438	136,560	0		2.00
3.00	SUBPROVIDER - IPF	40.00	341,895	248,101	0		3.00
4.00	NURSERY	43.00	297,132	9	0		4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	4,141,844	694,080	0		5.00
	0		6,325,412	1,405,317			
	C - CENTRAL SUPPLY						
1.00	ADULTS & PEDIATRICS	30.00	0	2,471,620	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	1,422,174	0		2.00
3.00	SUBPROVIDER - IPF	40.00	0	37,728	0		3.00
5.00	SKILLED NURSING FACILITY	44.00	0	51,199	0		5.00
6.00	OPERATING ROOM	50.00	0	22,663,296	0		6.00
7.00	RECOVERY ROOM	51.00	0	37,429	0		7.00
8.00	PERINATAL CLINIC	52.01	0	11,429	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	675,296	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,488,318	0		10.00
11.00	RADIOLOGY-THERAPEUTIC	55.00	0	19,452	0		11.00
12.00	RADIOISOTOPE	56.00	0	7,568	0		12.00
13.00	CT SCAN	57.00	0	220,126	0		13.00
14.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	19,501	0		14.00
15.00	CARDIAC CATHETERIZATION	59.00	0	12,203,700	0		15.00
16.00	LABORATORY	60.00	0	24,752	0		16.00
17.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	0	49	0		17.00
18.00	INTRAVENOUS THERAPY	64.00	0	298,961	0		18.00
19.00	RESPIRATORY THERAPY	65.00	0	344,600	0		19.00
20.00	PHYSICAL THERAPY	66.00	0	15,527	0		20.00
21.00	CLINICAL NUTRITION	66.01	0	85	0		21.00
22.00	OCCUPATIONAL THERAPY	67.00	0	18,786	0		22.00
23.00	SPEECH PATHOLOGY	68.00	0	633	0		23.00
24.00	ELECTROCARDIOLOGY	69.00	0	847,649	0		24.00
25.00	CARDIAC REHABILITATION	69.01	0	4,105	0		25.00
26.00	ELECTROENCEPHALOGRAPHY	70.00	0	65,539	0		26.00
27.00	ELECTROSHOCK THERAPY	70.01	0	14,187	0		27.00
28.00	RENAL DIALYSIS	74.00	0	41,984	0		28.00
29.00	ENDOSCOPY	76.00	0	544,462	0		29.00
30.00	CLINIC	90.00	0	91,879	0		30.00
31.00	EMERGENCY	91.00	0	1,301,266	0		31.00
32.00	RESEARCH	191.00	0	7	0		32.00
33.00	NON-REIMBURSABLE	194.00	0	73	0		33.00
34.00	DELIVERY ROOM & LABOR ROOM	52.00	0	319,990	0		34.00
	0		0	48,263,370			
	D - BHM - DEPT						
1.00	SUBPROVIDER - IPF	40.00	1,566,266	1,093,129	0		1.00
	0		1,566,266	1,093,129			
	E - BHM - ADMIN						
1.00	SUBPROVIDER - IPF	40.00	3,688,883	1,007,207	0		1.00
2.00		0.00	0	0	0		2.00
	0		3,688,883	1,007,207			
	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	387,922	841,404	0		1.00
	0		387,922	841,404			
	H - RESIDENCY ANCILLARY						
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	72,220	0		1.00
	0		0	72,220			
	I - PHARMACY RESIDENCY						
1.00	PHARMACY	15.00	83,665	0	0		1.00
	0		83,665	0			
500.00	Grand Total: Decreases		12,052,148	89,392,544			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 5/28/2019 12:59 pm

		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	2,865,359	0	0	0	0	2.00
3.00	Buildings and Fixtures	103,905,751	12,917,765	0	12,917,765	-477,316	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	3,686,594	80,026	0	80,026	-26,726	5.00
6.00	Movable Equipment	82,949,959	7,495,373	170,153	7,665,526	-4,639,554	6.00
7.00	HIT designated Assets	1,011,288	72,896	0	72,896	0	7.00
8.00	Subtotal (sum of lines 1-7)	204,034,343	20,566,060	170,153	20,736,213	-5,143,596	8.00
9.00	Reconciling Items	2,423,937	11,129,069	0	11,129,069	-29,285	9.00
10.00	Total (line 8 minus line 9)	201,610,406	9,436,991	170,153	9,607,144	-5,114,311	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	117,300,832	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	3,793,346	0	5.00
6.00	Movable Equipment	95,255,039	0	6.00
7.00	HIT designated Assets	1,084,184	0	7.00
8.00	Subtotal (sum of lines 1-7)	229,914,152	0	8.00
9.00	Reconciling Items	13,582,291	0	9.00
10.00	Total (line 8 minus line 9)	216,331,861	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 5/28/2019 12:59 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	6,466,926	0	1,702,690	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,328,907	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	12,795,833	0	1,702,690	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	8,169,616	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	6,328,907	2.00
3.00	Total (sum of lines 1-2)	0	14,498,523	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 5/28/2019 12:59 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	128,826,951	0	128,826,951	0.586572	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	90,800,010	0	90,800,010	0.413428	0	2.00
3.00	Total (sum of lines 1-2)	219,626,961	0	219,626,961	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	6,908,147	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	8,752,120	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	15,660,267	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	1,702,690	0	0	0	8,610,837	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	-1,202,153	0	0	0	7,549,967	2.00
3.00	Total (sum of lines 1-2)	500,537	0	0	0	16,160,804	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/28/2019 12:59 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		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	-13,012,082			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	-14,930,618			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	-91,844	SKILLED NURSING FACILITY	44.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/28/2019 12:59 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	GIFT	A	-13,530	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	GIFT	A	-473,471	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	GIFT	A	-2,970	NURSING ADMINISTRATION	13.00	0	33.03
33.04	GIFT	A	-750	PHARMACY	15.00	0	33.04
33.05	GIFT	A	0	ADULTS & PEDIATRICS	30.00	0	33.05
33.06	GIFT	A	-80	INTENSIVE CARE UNIT	31.00	0	33.06
33.07	GIFT	A	-402	SUBPROVIDER - IPF	40.00	0	33.07
33.08	GIFT	A	-1,309	SKILLED NURSING FACILITY	44.00	0	33.08
33.09	GIFT	A	-117	OPERATING ROOM	50.00	0	33.09
33.10	GIFT	A	-14	RECOVERY ROOM	51.00	0	33.10
33.11	GIFT	A	-167	RADIOLOGY-DIAGNOSTIC	54.00	0	33.11
33.12	GIFT	A	-341	RESPIRATORY THERAPY	65.00	0	33.12
33.13	GIFT	A	-8	ELECTROCARDIOLOGY	69.00	0	33.13
33.14	GIFT	A	-16	ENDOSCOPY	76.00	0	33.14
33.15	GIFT	A	-138	CLINIC	90.00	0	33.15
33.16	GIFT	A	-1,859	EMERGENCY	91.00	0	33.16
33.17	PHONE	A	-36,807	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	PHONE	A	-562	OPERATION OF PLANT	7.00	0	33.18
33.19	PHONE	A	-311	DIETARY	10.00	0	33.19
33.20	PHONE	A	-58	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	33.20
33.21	PHONE	A	-4,977	SKILLED NURSING FACILITY	44.00	0	33.21
33.22	PHONE	A	-6,393	CLINIC	90.00	0	33.22
33.23	PHONE	A	-132	EMERGENCY	91.00	0	33.23
33.24	ENTERTAINMENT	A	-47,184	ADMINISTRATIVE & GENERAL	5.00	0	33.24
33.25	ENTERTAINMENT	A	-594	NURSING ADMINISTRATION	13.00	0	33.25
33.26	ENTERTAINMENT	A	-267	SKILLED NURSING FACILITY	44.00	0	33.26
33.27	ENTERTAINMENT	A	-881	RADIOLOGY-DIAGNOSTIC	54.00	0	33.27
33.28	ENTERTAINMENT	A	-100	RADIOLOGY-THERAPEUTIC	55.00	0	33.28
33.29	ENTERTAINMENT	A	-60	SUBPROVIDER - IPF	40.00	0	33.29
33.30	NURSE PARCTIONER	A	-20,536	ADULTS & PEDIATRICS	30.00	0	33.30
33.31	NURSE PRACTIONER	A	-11,890	SUBPROVIDER - IPF	40.00	0	33.31
33.32	NON-MEDICAL TRANSPORT	A	-87,578	SOCIAL SERVICE	17.00	0	33.32
33.33	NON-MEDICAL TRANSPORT	A	-1,593	ADULTS & PEDIATRICS	30.00	0	33.33
33.34	NON-MEDICAL TRANSPORT	A	-127,150	SUBPROVIDER - IPF	40.00	0	33.34
33.35	NON-MEDICAL TRANSPORT	A	-449	SKILLED NURSING FACILITY	44.00	0	33.35
33.36	NON-MEDICAL TRANSPORT	A	-80,547	CLINIC	90.00	0	33.36
33.37	NON-MEDICAL TRANSPORT	A	-375	EMERGENCY	91.00	0	33.37
33.38	MARKETING	A	-11,552	ADMINISTRATIVE & GENERAL	5.00	9	33.38
33.39	MARKETING	A	-210	ADULTS & PEDIATRICS	30.00	0	33.39
33.40	MARKETING	A	-23,894	SKILLED NURSING FACILITY	44.00	0	33.40
33.41	MARKETING	A	-50	ELECTROCARDIOLOGY	69.00	0	33.41
33.42	MARKETING	A	-17	CLINIC	90.00	0	33.42
33.43	MARKETING	A	-545	EMERGENCY	91.00	0	33.43
33.44	FRA	A	-93,626	ADMINISTRATIVE & GENERAL	5.00	0	33.44
33.45	MISCELLANEOUS REVENUE	B	-1,520,127	ADMINISTRATIVE & GENERAL	5.00	0	33.45
33.46	MISCELLANEOUS REVENUE	B	-300,613	OPERATION OF PLANT	7.00	0	33.46
33.47	MISCELLANEOUS REVENUE	B	-1,754,342	DIETARY	10.00	0	33.47
33.48	MISCELLANEOUS REVENUE	B	-25,408	PHARMACY	15.00	0	33.48
33.49	MISCELLANEOUS REVENUE	B	-2,852	MEDICAL RECORDS & LIBRARY	16.00	0	33.49
33.50	MISCELLANEOUS REVENUE	B	-12,500	PHARMACY RESIDENCY PROGRAM	23.00	0	33.50
33.51	MISCELLANEOUS REVENUE	B	-16,032	ADULTS & PEDIATRICS	30.00	0	33.51
33.52	MISCELLANEOUS REVENUE	B	-56	SUBPROVIDER - IPF	40.00	0	33.52
33.53	MISCELLANEOUS REVENUE	B	-572	OPERATING ROOM	50.00	0	33.53
33.54	MISCELLANEOUS REVENUE	B	-8	RECOVERY ROOM	51.00	0	33.54
33.55	MISCELLANEOUS REVENUE	B	-5,844	PERINATAL CLINIC	52.01	0	33.55
33.56	MISCELLANEOUS REVENUE	B	-16,344	ANESTHESIOLOGY	53.00	0	33.56
33.57	MISCELLANEOUS REVENUE	B	-516,171	RADIOLOGY-DIAGNOSTIC	54.00	0	33.57
33.58	MISCELLANEOUS REVENUE	B	-31,391	RADIOLOGY-THERAPEUTIC	55.00	0	33.58
33.59	MISCELLANEOUS REVENUE	B	-2,527	RADIOISOTOPE	56.00	0	33.59
33.60	MISCELLANEOUS REVENUE	B	-54,893	CT SCAN	57.00	0	33.60
33.61	MISCELLANEOUS REVENUE	B	-24,519	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	33.61
33.62	MISCELLANEOUS REVENUE	B	-8,809	CARDIAC CATHETERIZATION	59.00	0	33.62
33.63	MISCELLANEOUS REVENUE	B	-1,649,416	LABORATORY	60.00	0	33.63
33.64	MISCELLANEOUS REVENUE	B	-74,297	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	0	33.64
33.65	MISCELLANEOUS REVENUE	B	-77,481	INTRAVENOUS THERAPY	64.00	0	33.65
33.66	MISCELLANEOUS REVENUE	B	-321	RESPIRATORY THERAPY	65.00	0	33.66

ADJUSTMENTS TO EXPENSES | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/28/2019 12:59 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.67	MISCELLANEOUS REVENUE	B	-70,888	CLINICAL NUTRITION	66.01	0	33.67
33.68	MISCELLANEOUS REVENUE	B	-21,854	ELECTROCARDIOLOGY	69.00	0	33.68
33.69	MISCELLANEOUS REVENUE	B	-267	ELECTROENCEPHALOGRAPHY	70.00	0	33.69
33.70	MISCELLANEOUS REVENUE	B	-794	RENAL DIALYSIS	74.00	0	33.70
33.71	MISCELLANEOUS REVENUE	B	-1,033	ENDOSCOPY	76.00	0	33.71
33.72	MISCELLANEOUS REVENUE	B	-509,450	CLINIC	90.00	0	33.72
33.73	MISCELLANEOUS REVENUE	B	-7,902	EMERGENCY	91.00	0	33.73
33.74	LOBBYING	A	-22,944	ADMINISTRATIVE & GENERAL	5.00	0	33.74
33.75	LOBBYING	A	-20	EMERGENCY	91.00	0	33.75
33.76	MISC MD COMPENSATION	A	-961,188	CLINIC	90.00	0	33.76
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-36,778,917				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 01/01/2018 To 12/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 5/28/2019 12:59 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	494,002	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	2,423,213	0	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE - INTEREST	500,379	1,702,532	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	16,372,472	24,278,644	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	30,290,441	37,283,551	4.01
4.02	7.00	OPERATION OF PLANT	HOME OFFICE	0	1,226,000	4.02
4.03	71.00	MEDICAL SUPPLIES CHARGED TO	HOME OFFICE	-1,231,836	0	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	NETWORK--CORP 130	13,076,280	12,337,354	4.04
4.05	13.00	NURSING ADMINISTRATION	NETWORK--CORP 130	204,943	204,943	4.05
4.06	30.00	ADULTS & PEDIATRICS	NETWORK--CORP 130	346,376	347,729	4.06
4.07	40.00	SUBPROVIDER - IPF	NETWORK--CORP 130	2,276,095	2,301,819	4.07
4.08	55.00	RADIOLOGY-THERAPEUTIC	NETWORK--CORP 130	104,359	104,766	4.08
4.09	70.00	ELECTROENCEPHALOGRAPHY	NETWORK--CORP 130	1,024	1,028	4.09
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			64,857,748	79,788,366	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 01/01/2018 To 12/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 5/28/2019 12:59 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	494,002	9		1.00
2.00	2,423,213	9		2.00
3.00	-1,202,153	11		3.00
4.00	-7,906,172	0		4.00
4.01	-6,993,110	0		4.01
4.02	-1,226,000	0		4.02
4.03	-1,231,836	0		4.03
4.04	738,926	0		4.04
4.05	0	0		4.05
4.06	-1,353	0		4.06
4.07	-25,724	0		4.07
4.08	-407	0		4.08
4.09	-4	0		4.09
5.00	-14,930,618			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 01/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 5/28/2019 12:59 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	521,392	128,573	392,819	179,000	64,788	1.00
2.00	15.00	PHARMACY	3,926	3,926	0	179,000	0	2.00
3.00	21.00	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	179,000	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	3,533,061	3,289,538	243,523	179,000	2,288	4.00
5.00	31.00	INTENSIVE CARE UNIT	2,055,909	2,055,909	0	179,000	0	5.00
6.00	40.00	SUBPROVIDER - IPF	1,162,921	1,162,921	0	181,300	164	6.00
7.00	50.00	OPERATING ROOM	187,218	9,339	177,879	246,400	1,406	7.00
8.00	52.01	PERINATAL CLINIC	605,834	605,834	0	237,100	0	8.00
9.00	53.00	ANESTHESIOLOGY	2,711,457	2,608,681	102,776	239,400	523	9.00
10.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	271,900	0	10.00
11.00	60.00	LABORATORY	263,599	224,444	39,155	260,300	354	11.00
12.00	64.00	INTRAVENOUS THERAPY	8,505	8,505	0	179,000	0	12.00
13.00	65.00	RESPIRATORY THERAPY	28,227	0	28,227	179,000	188	13.00
14.00	69.00	ELECTROCARDIOLOGY	335,924	335,924	0	179,000	0	14.00
15.00	69.01	CARDIAC REHABILITATION	5,292	0	5,292	179,000	23	15.00
16.00	70.00	ELECTROENCEPHALOGRAPHY	26,163	0	26,163	179,000	262	16.00
17.00	74.00	RENAL DIALYSIS	0	0	0	179,000	0	17.00
18.00	90.00	CLINIC	1,006,350	962,660	43,690	179,000	371	18.00
19.00	91.00	EMERGENCY	1,484,562	1,484,562	0	179,000	0	19.00
200.00			13,940,340	12,880,816	1,059,524		70,367	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	5,575,506	278,775	0	0	0	1.00
2.00	15.00	PHARMACY	0	0	0	0	0	2.00
3.00	21.00	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	196,900	9,845	0	0	0	4.00
5.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	5.00
6.00	40.00	SUBPROVIDER - IPF	14,295	715	0	0	0	6.00
7.00	50.00	OPERATING ROOM	166,557	8,328	0	0	0	7.00
8.00	52.01	PERINATAL CLINIC	0	0	0	0	0	8.00
9.00	53.00	ANESTHESIOLOGY	60,195	3,010	0	0	0	9.00
10.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	10.00
11.00	60.00	LABORATORY	44,301	2,215	0	0	0	11.00
12.00	64.00	INTRAVENOUS THERAPY	0	0	0	0	0	12.00
13.00	65.00	RESPIRATORY THERAPY	16,179	809	0	0	0	13.00
14.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	14.00
15.00	69.01	CARDIAC REHABILITATION	1,979	99	0	0	0	15.00
16.00	70.00	ELECTROENCEPHALOGRAPHY	22,547	1,127	0	0	0	16.00
17.00	74.00	RENAL DIALYSIS	0	0	0	0	0	17.00
18.00	90.00	CLINIC	31,927	1,596	0	0	0	18.00
19.00	91.00	EMERGENCY	0	0	0	0	0	19.00
200.00			6,130,386	306,519	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	5,575,506	0	128,573		1.00
2.00	15.00	PHARMACY	0	0	0	3,926		2.00
3.00	21.00	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0		3.00
4.00	30.00	ADULTS & PEDIATRICS	0	196,900	46,623	3,336,161		4.00
5.00	31.00	INTENSIVE CARE UNIT	0	0	0	2,055,909		5.00
6.00	40.00	SUBPROVIDER - IPF	0	14,295	0	1,162,921		6.00
7.00	50.00	OPERATING ROOM	0	166,557	11,322	20,661		7.00
8.00	52.01	PERINATAL CLINIC	0	0	0	605,834		8.00
9.00	53.00	ANESTHESIOLOGY	0	60,195	42,581	2,651,262		9.00
10.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0		10.00
11.00	60.00	LABORATORY	0	44,301	0	224,444		11.00
12.00	64.00	INTRAVENOUS THERAPY	0	0	0	8,505		12.00
13.00	65.00	RESPIRATORY THERAPY	0	16,179	12,048	12,048		13.00
14.00	69.00	ELECTROCARDIOLOGY	0	0	0	335,924		14.00
15.00	69.01	CARDIAC REHABILITATION	0	1,979	3,313	3,313		15.00
16.00	70.00	ELECTROENCEPHALOGRAPHY	0	22,547	3,616	3,616		16.00
17.00	74.00	RENAL DIALYSIS	0	0	0	0		17.00
18.00	90.00	CLINIC	0	31,927	11,763	974,423		18.00
19.00	91.00	EMERGENCY	0	0	0	1,484,562		19.00
200.00			0	6,130,386	131,266	13,012,082		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/28/2019 12:59 pm

		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	8,610,837	8,610,837				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	7,549,967		7,549,967			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	25,623,918	35,787	0	25,659,705		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	82,573,179	1,442,977	330,500	2,484,468	86,831,124	5.00
7.00	00700	OPERATION OF PLANT	9,450,020	783,929	629,757	354,731	11,218,437	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,073,576	26,959	0	28,007	1,128,542	8.00
9.00	00900	HOUSEKEEPING	4,272,193	20,948	19,910	562,767	4,875,818	9.00
10.00	01000	DIETARY	5,676,109	213,116	97,632	515,437	6,502,294	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,185,420	81,050	506,327	497,354	4,270,151	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,636,971	236,366	174,338	144,407	3,192,082	14.00
15.00	01500	PHARMACY	6,547,977	34,942	13,529	1,029,193	7,625,641	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	577,314	53,968	2,341	79,270	712,893	16.00
17.00	01700	SOCIAL SERVICE	577,788	14,692	0	95,729	688,209	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	974,498	0	0	199,867	1,174,365	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	72,220	0	0	0	72,220	22.00
23.00	02300	PHARMACY RESIDENCY PROGRAM	381,528	6,587	0	76,687	464,802	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,699,444	2,135,474	407,178	7,601,297	47,843,393	30.00
31.00	03100	INTENSIVE CARE UNIT	9,092,262	261,012	202,892	1,774,836	11,331,002	31.00
40.00	04000	SUBPROVIDER - IPF	754,350	393,789	31,021	389,769	1,568,929	40.00
43.00	04300	NURSERY	1,461,365	86,804	0	256,702	1,804,871	43.00
44.00	04400	SKILLED NURSING FACILITY	4,144,412	0	58,005	0	4,202,417	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,365,111	742,498	916,118	1,732,630	16,756,357	50.00
51.00	05100	RECOVERY ROOM	1,041,992	0	41,946	209,442	1,293,380	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,913,920	0	107,858	410,425	2,432,203	52.00
52.01	05201	PERINATAL CLINIC	718,241	108,952	28,762	127,651	983,606	52.01
53.00	05300	ANESTHESIOLOGY	656,706	187,063	33,568	15,718	893,055	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,593,576	10,958	533,139	713,865	7,851,538	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,932,992	297,166	1,328,886	441,070	5,000,114	55.00
56.00	05600	RADIOISOTOPE	1,123,016	188,226	90,497	61,092	1,462,831	56.00
57.00	05700	CT SCAN	1,194,501	18,634	104,447	172,600	1,490,182	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	452,595	0	929,616	71,719	1,453,930	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,724,858	34,073	181,169	270,505	2,210,605	59.00
60.00	06000	LABORATORY	2,972,852	95,031	39,869	405,887	3,513,639	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,863,532	276,756	4,329	88,806	3,233,423	62.00
64.00	06400	INTRAVENOUS THERAPY	2,255,082	10,174	18,349	379,218	2,662,823	64.00
65.00	06500	RESPIRATORY THERAPY	3,294,826	0	140,905	466,782	3,902,513	65.00
66.00	06600	PHYSICAL THERAPY	2,402,879	99,267	0	0	2,502,146	66.00
66.01	06601	CLINICAL NUTRITION	643,906	97,798	0	145,956	887,660	66.01
67.00	06700	OCCUPATIONAL THERAPY	896,613	0	0	0	896,613	67.00
68.00	06800	SPEECH PATHOLOGY	449,115	52,217	1,197	0	502,529	68.00
69.00	06900	ELECTROCARDIOLOGY	3,397,047	1,212	215,725	560,668	4,174,652	69.00
69.01	06901	CARDIAC REHABILITATION	316,533	0	11,605	64,307	392,445	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	387,038	128,626	80,363	62,902	658,929	70.00
70.01	07001	ELECTROSHOCK THERAPY	94,859	8,423	1,631	18,850	123,763	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	25,448,486	0	0	0	25,448,486	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,583,048	0	0	0	21,583,048	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,554,963	0	0	0	35,554,963	73.00
74.00	07400	RENAL DIALYSIS	1,839,663	0	2,116	0	1,841,779	74.00
76.00	03330	ENDOSCOPY	1,462,738	18,144	69,912	201,357	1,752,151	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	8,596,923	50,515	4,045	1,192,615	9,844,098	90.00
91.00	09100	EMERGENCY	9,494,724	319,289	181,142	1,712,281	11,707,436	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)	368,607,683	8,573,422	7,540,624	25,616,867	368,518,087	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	139,021	20,630	1,713	11,505	172,869	190.00
191.00	19100	RESEARCH	89,842	0	0	18,425	108,267	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	12,647	0	0	12,647	192.00
194.00	07951	NON-REIMBURSABLE	74,080	4,138	7,630	12,908	98,756	194.00
194.01	07950	OTHER	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	12,419,573	0	0	0	12,419,573	194.03
200.00		Cross Foot Adjustments					0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/28/2019 12:59 pm

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	381,330,199	8,610,837	7,549,967	25,659,705	381,330,199	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/28/2019 12:59 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	86,831,124					5.00
7.00	00700	OPERATION OF PLANT	3,307,678	14,526,115				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	332,743	61,690	1,522,975			8.00
9.00	00900	HOUSEKEEPING	1,437,601	47,934	0	6,361,353		9.00
10.00	01000	DIETARY	1,917,156	487,663	0	215,184	9,122,297	10.00
11.00	01100	CAFETERIA	0	0	0	0	6,141,931	11.00
13.00	01300	NURSING ADMINISTRATION	1,259,024	185,461	0	81,836	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	941,163	540,864	0	238,659	0	14.00
15.00	01500	PHARMACY	2,248,367	79,956	0	35,281	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	210,192	123,492	0	54,491	0	16.00
17.00	01700	SOCIAL SERVICE	202,914	33,618	0	14,834	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	346,253	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	21,294	0	0	0	0	22.00
23.00	02300	PHARMACY RESIDENCY PROGRAM	137,044	15,072	0	6,651	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,106,418	4,886,488	105,035	2,156,189	2,310,034	30.00
31.00	03100	INTENSIVE CARE UNIT	3,340,867	597,259	30,679	263,544	397,995	31.00
40.00	04000	SUBPROVIDER - IPF	462,588	901,085	0	397,609	168,422	40.00
43.00	04300	NURSERY	532,154	198,629	74,161	87,646	60,682	43.00
44.00	04400	SKILLED NURSING FACILITY	1,239,053	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,940,495	1,699,018	401,578	749,700	0	50.00
51.00	05100	RECOVERY ROOM	381,344	0	31,931	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	717,118	0	289,302	0	43,233	52.00
52.01	05201	PERINATAL CLINIC	290,009	249,308	16,359	110,009	0	52.01
53.00	05300	ANESTHESIOLOGY	263,311	428,046	3,637	188,878	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,314,971	25,074	196,902	11,064	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,474,249	679,988	10,546	300,048	0	55.00
56.00	05600	RADIOISOTOPE	431,305	430,708	0	190,052	0	56.00
57.00	05700	CT SCAN	439,370	42,639	0	18,815	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	428,681	0	8,298	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	651,781	77,967	8,099	34,403	0	59.00
60.00	06000	LABORATORY	1,035,972	217,455	41,415	95,953	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	953,352	633,286	0	279,441	0	62.00
64.00	06400	INTRAVENOUS THERAPY	785,115	23,281	4,049	10,273	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,150,629	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	737,740	227,148	3,319	100,230	0	66.00
66.01	06601	CLINICAL NUTRITION	261,720	223,786	0	98,747	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	264,360	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	148,167	119,485	0	52,724	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,230,867	2,774	48,807	1,224	0	69.00
69.01	06901	CARDIAC REHABILITATION	115,710	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	194,281	294,329	0	129,874	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	36,491	19,275	0	8,505	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,503,308	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,363,611	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,483,132	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	543,036	0	9,517	0	0	74.00
76.00	03330	ENDOSCOPY	516,609	41,519	45,644	18,320	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,902,463	115,591	0	51,005	0	90.00
91.00	09100	EMERGENCY	3,451,856	730,612	190,586	322,386	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)	83,053,562	14,440,500	1,519,864	6,323,575	9,122,297	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	50,969	47,206	0	20,830	0	190.00
191.00	19100	RESEARCH	31,922	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,729	28,940	0	12,770	0	192.00
194.00	07951	NON-REIMBURSABLE	29,118	9,469	3,111	4,178	0	194.00
194.01	07950	OTHER	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	3,661,824	0	0	0	0	194.03
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)	86,831,124	14,526,115	1,522,975	6,361,353	9,122,297	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/28/2019 12:59 pm

		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	6,141,931					11.00
13.00	01300	NURSING ADMINISTRATION	30,755	5,827,227				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	265,800	0	5,178,568			14.00
15.00	01500	PHARMACY	691,408	0	0	10,680,653		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	141,791	0	0	0	1,242,859	16.00
17.00	01700	SOCIAL SERVICE	88,310	0	0	793	0	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	58,652	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	979,908	2,658,025	460,527	32,557	150,054	30.00
31.00	03100	INTENSIVE CARE UNIT	282,021	604,199	273,812	15,060	32,645	31.00
40.00	04000	SUBPROVIDER - IPF	0	380,620	7,323	325	7,664	40.00
43.00	04300	NURSERY	223,287	65,575	0	0	256	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	9,938	61,683	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	428,303	448,212	1,717,416	37,526	112,458	50.00
51.00	05100	RECOVERY ROOM	14,325	63,791	7,265	1,762	11,664	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	419,836	62,018	2,414	14,857	52.00
52.01	05201	PERINATAL CLINIC	75,037	16,491	2,195	0	5,258	52.01
53.00	05300	ANESTHESIOLOGY	0	12,998	131,073	2,770	30,984	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	580,046	81,993	718,332	10,291	67,728	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	219,522	14,372	3,776	0	41,184	55.00
56.00	05600	RADIOISOTOPE	46,613	0	1,469	226	8,419	56.00
57.00	05700	CT SCAN	162,893	7	41,990	2,921	65,391	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	67,017	30	3,785	162	18,839	58.00
59.00	05900	CARDIAC CATHETERIZATION	47,530	72,554	1,058,557	7,188	43,756	59.00
60.00	06000	LABORATORY	389,473	0	4,737	0	79,394	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	87,783	3	10	0	9,552	62.00
64.00	06400	INTRAVENOUS THERAPY	11,077	101,331	58,027	705	14,217	64.00
65.00	06500	RESPIRATORY THERAPY	449,468	0	66,886	390	23,730	65.00
66.00	06600	PHYSICAL THERAPY	0	0	3,014	0	6,017	66.00
66.01	06601	CLINICAL NUTRITION	167,710	0	16	0	191	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	3,646	0	2,867	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	123	0	2,058	68.00
69.00	06900	ELECTROCARDIOLOGY	163,020	180,074	144,864	480	66,091	69.00
69.01	06901	CARDIAC REHABILITATION	1,769	21,715	797	51	893	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,130	12,721	2	6,915	70.00
70.01	07001	ELECTROSHOCK THERAPY	73	7,983	2,754	1	840	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	23,918	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	34,620	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,169,203	235,148	73.00
74.00	07400	RENAL DIALYSIS	0	0	8,149	1,641	6,039	74.00
76.00	03330	ENDOSCOPY	8,328	71,351	104,554	1,975	14,081	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	265,519	44,690	17,812	320,684	21,491	90.00
91.00	09100	EMERGENCY	148,541	549,821	250,967	9,843	83,640	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)	6,095,979	5,820,801	5,178,553	10,680,653	1,242,859	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	25,675	161	0	0	0	190.00
191.00	19100	RESEARCH	0	6,058	1	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	NON-REIMBURSABLE	20,277	207	14	0	0	194.00
194.01	07950	OTHER	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	0	0	0	0	0	194.03
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)	6,141,931	5,827,227	5,178,568	10,680,653	1,242,859	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/28/2019 12:59 pm

		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	1,028,678					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	1,520,618				21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0		93,514			22.00
23.00	02300	PHARMACY RESIDENCY PROGRAM	0			682,221		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	797,315	1,344,266	82,670	127,916	78,040,795	30.00
31.00	03100	INTENSIVE CARE UNIT	137,369	0	0	170,557	17,477,009	31.00
40.00	04000	SUBPROVIDER - IPF	58,130	0	0	127,916	4,080,611	40.00
43.00	04300	NURSERY	20,944	0	0	0	3,068,205	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	5,513,091	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	76,530	4,706	0	27,372,299	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	1,805,462	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,920	0	0	0	3,995,901	52.00
52.01	05201	PERINATAL CLINIC	0	0	0	0	1,748,272	52.01
53.00	05300	ANESTHESIOLOGY	0	16,637	1,023	0	1,972,412	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	33,274	2,046	0	11,893,259	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	7,743,799	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	2,571,623	56.00
57.00	05700	CT SCAN	0	0	0	0	2,264,208	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	1,980,742	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	16,637	1,023	0	4,230,100	59.00
60.00	06000	LABORATORY	0	0	0	0	5,378,038	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	5,196,850	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	3,670,898	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	5,593,616	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	3,579,614	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	0	1,639,830	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	1,167,486	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	825,086	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	127,916	6,140,769	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	533,380	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	1,302,181	70.00
70.01	07001	ELECTROSHOCK THERAPY	0	0	0	0	199,685	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	32,975,712	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	27,981,279	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	56,442,446	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	2,410,161	74.00
76.00	03330	ENDOSCOPY	0	0	0	0	2,574,532	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	13,583,353	90.00
91.00	09100	EMERGENCY	0	33,274	2,046	127,916	17,608,924	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)	1,028,678	1,520,618	93,514	682,221	364,561,628	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	317,710	190.00
191.00	19100	RESEARCH	0	0	0	0	146,248	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	58,086	192.00
194.00	07951	NON-REIMBURSABLE	0	0	0	0	165,130	194.00
194.01	07950	OTHER	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	0	0	0	0	16,081,397	194.03
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)	1,028,678	1,520,618	93,514	682,221	381,330,199	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/28/2019 12:59 pm

		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	-1,426,936	76,613,859		30.00
31.00	03100	INTENSIVE CARE UNIT	0	17,477,009		31.00
40.00	04000	SUBPROVIDER - IPF	0	4,080,611		40.00
43.00	04300	NURSERY	0	3,068,205		43.00
44.00	04400	SKILLED NURSING FACILITY	0	5,513,091		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-81,236	27,291,063		50.00
51.00	05100	RECOVERY ROOM	0	1,805,462		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,995,901		52.00
52.01	05201	PERINATAL CLINIC	0	1,748,272		52.01
53.00	05300	ANESTHESIOLOGY	-17,660	1,954,752		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-35,320	11,857,939		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	7,743,799		55.00
56.00	05600	RADIOISOTOPE	0	2,571,623		56.00
57.00	05700	CT SCAN	0	2,264,208		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,980,742		58.00
59.00	05900	CARDIAC CATHETERIZATION	-17,660	4,212,440		59.00
60.00	06000	LABORATORY	0	5,378,038		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	5,196,850		62.00
64.00	06400	INTRAVENOUS THERAPY	0	3,670,898		64.00
65.00	06500	RESPIRATORY THERAPY	0	5,593,616		65.00
66.00	06600	PHYSICAL THERAPY	0	3,579,614		66.00
66.01	06601	CLINICAL NUTRITION	0	1,639,830		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	1,167,486		67.00
68.00	06800	SPEECH PATHOLOGY	0	825,086		68.00
69.00	06900	ELECTROCARDIOLOGY	0	6,140,769		69.00
69.01	06901	CARDIAC REHABILITATION	0	533,380		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,302,181		70.00
70.01	07001	ELECTROSHOCK THERAPY	0	199,685		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	32,975,712		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	27,981,279		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	56,442,446		73.00
74.00	07400	RENAL DIALYSIS	0	2,410,161		74.00
76.00	03330	ENDOSCOPY	0	2,574,532		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	13,583,353		90.00
91.00	09100	EMERGENCY	-35,320	17,573,604		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)	-1,614,132	362,947,496		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	317,710		190.00
191.00	19100	RESEARCH	0	146,248		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	58,086		192.00
194.00	07951	NON-REIMBURSABLE	0	165,130		194.00
194.01	07950	OTHER	0	0		194.01
194.02	07952	OTHER NONREIMBURSABLE	0	0		194.02
194.03	07953	RETAIL PHARMACY	0	16,081,397		194.03
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)	-1,614,132	379,716,067		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/28/2019 12:59 pm

		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	35,787	0	35,787	35,787	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,932,693	1,442,977	330,500	5,706,170	3,465	5.00
7.00	00700	OPERATION OF PLANT	0	783,929	629,757	1,413,686	495	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	26,959	0	26,959	39	8.00
9.00	00900	HOUSEKEEPING	0	20,948	19,910	40,858	785	9.00
10.00	01000	DIETARY	24,770	213,116	97,632	335,518	719	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	81,050	506,327	587,377	694	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	112,107	236,366	174,338	522,811	201	14.00
15.00	01500	PHARMACY	520,320	34,942	13,529	568,791	1,435	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	53,968	2,341	56,309	111	16.00
17.00	01700	SOCIAL SERVICE	0	14,692	0	14,692	133	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	28,626	0	0	28,626	279	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	795	6,587	0	7,382	107	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,073	2,135,474	407,178	2,543,725	10,601	30.00
31.00	03100	INTENSIVE CARE UNIT	0	261,012	202,892	463,904	2,475	31.00
40.00	04000	SUBPROVIDER - IPF	122	393,789	31,021	424,932	544	40.00
43.00	04300	NURSERY	0	86,804	0	86,804	358	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	58,005	58,005	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,599,664	742,498	916,118	3,258,280	2,416	50.00
51.00	05100	RECOVERY ROOM	0	0	41,946	41,946	292	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	107,858	107,858	572	52.00
52.01	05201	PERINATAL CLINIC	143,095	108,952	28,762	280,809	178	52.01
53.00	05300	ANESTHESIOLOGY	107,635	187,063	33,568	328,266	22	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	194,462	10,958	533,139	738,559	996	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	660,414	297,166	1,328,886	2,286,466	615	55.00
56.00	05600	RADIOISOTOPE	0	188,226	90,497	278,723	85	56.00
57.00	05700	CT SCAN	18,000	18,634	104,447	141,081	241	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	929,616	929,616	100	58.00
59.00	05900	CARDIAC CATHETERIZATION	13,934	34,073	181,169	229,176	377	59.00
60.00	06000	LABORATORY	10,857	95,031	39,869	145,757	566	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	276,756	4,329	281,085	124	62.00
64.00	06400	INTRAVENOUS THERAPY	312,700	10,174	18,349	341,223	529	64.00
65.00	06500	RESPIRATORY THERAPY	109,128	0	140,905	250,033	651	65.00
66.00	06600	PHYSICAL THERAPY	0	99,267	0	99,267	0	66.00
66.01	06601	CLINICAL NUTRITION	0	97,798	0	97,798	204	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	52,217	1,197	53,414	0	68.00
69.00	06900	ELECTROCARDIOLOGY	348,062	1,212	215,725	564,999	782	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	11,605	11,605	90	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	128,626	80,363	208,989	88	70.00
70.01	07001	ELECTROSHOCK THERAPY	0	8,423	1,631	10,054	26	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	2,116	2,116	0	74.00
76.00	03330	ENDOSCOPY	309,846	18,144	69,912	397,902	281	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,188,199	50,515	4,045	1,242,759	1,663	90.00
91.00	09100	EMERGENCY	149,672	319,289	181,142	650,103	2,388	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)	9,786,174	8,573,422	7,540,624	25,900,220	35,727	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	20,630	1,713	22,343	16	190.00
191.00	19100	RESEARCH	0	0	0	0	26	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	12,647	0	12,647	0	192.00
194.00	07951	NON-REIMBURSABLE	0	4,138	7,630	11,768	18	194.00
194.01	07950	OTHER	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/28/2019 12:59 pm

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
202.00	TOTAL (sum lines 118 through 201)	9,786,174	8,610,837	7,549,967	25,946,978	35,787	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/28/2019 12:59 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,709,635					5.00
7.00	00700	OPERATION OF PLANT	217,503	1,631,684				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	21,880	6,929	55,807			8.00
9.00	00900	HOUSEKEEPING	94,532	5,384	0	141,559		9.00
10.00	01000	DIETARY	126,066	54,778	0	4,788	521,869	10.00
11.00	01100	CAFETERIA	0	0	0	0	351,368	11.00
13.00	01300	NURSING ADMINISTRATION	82,790	20,832	0	1,821	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	61,888	60,754	0	5,311	0	14.00
15.00	01500	PHARMACY	147,846	8,981	0	785	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,822	13,872	0	1,213	0	16.00
17.00	01700	SOCIAL SERVICE	13,343	3,776	0	330	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	22,769	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	1,400	0	0	0	0	22.00
23.00	02300	PHARMACY RESIDENCY PROGRAM	9,012	1,693	0	148	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	927,473	548,888	3,849	47,983	132,153	30.00
31.00	03100	INTENSIVE CARE UNIT	219,685	67,089	1,124	5,865	22,769	31.00
40.00	04000	SUBPROVIDER - IPF	30,418	101,217	0	8,848	9,635	40.00
43.00	04300	NURSERY	34,993	22,311	2,718	1,950	3,471	43.00
44.00	04400	SKILLED NURSING FACILITY	81,476	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	324,872	190,847	14,715	16,683	0	50.00
51.00	05100	RECOVERY ROOM	25,076	0	1,170	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	47,156	0	10,601	0	2,473	52.00
52.01	05201	PERINATAL CLINIC	19,070	28,004	599	2,448	0	52.01
53.00	05300	ANESTHESIOLOGY	17,315	48,081	133	4,203	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	152,226	2,816	7,215	246	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	96,942	76,381	386	6,677	0	55.00
56.00	05600	RADIOISOTOPE	28,361	48,380	0	4,229	0	56.00
57.00	05700	CT SCAN	28,892	4,790	0	419	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	28,189	0	304	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	42,859	8,758	297	766	0	59.00
60.00	06000	LABORATORY	68,122	24,426	1,518	2,135	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	62,690	71,136	0	6,218	0	62.00
64.00	06400	INTRAVENOUS THERAPY	51,627	2,615	148	229	0	64.00
65.00	06500	RESPIRATORY THERAPY	75,662	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	48,512	25,515	122	2,230	0	66.00
66.01	06601	CLINICAL NUTRITION	17,210	25,137	0	2,197	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	17,384	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	9,743	13,422	0	1,173	0	68.00
69.00	06900	ELECTROCARDIOLOGY	80,938	312	1,788	27	0	69.00
69.01	06901	CARDIAC REHABILITATION	7,609	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	12,775	33,061	0	2,890	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	2,400	2,165	0	189	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	493,395	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	418,452	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	689,340	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	35,708	0	349	0	0	74.00
76.00	03330	ENDOSCOPY	33,971	4,664	1,673	408	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	190,857	12,984	0	1,135	0	90.00
91.00	09100	EMERGENCY	226,984	82,068	6,984	7,174	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)	5,461,233	1,622,066	55,693	140,718	521,869	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,352	5,303	0	464	0	190.00
191.00	19100	RESEARCH	2,099	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	245	3,251	0	284	0	192.00
194.00	07951	NON-REIMBURSABLE	1,915	1,064	114	93	0	194.00
194.01	07950	OTHER	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	240,791	0	0	0	0	194.03
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)	5,709,635	1,631,684	55,807	141,559	521,869	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/28/2019 12:59 pm

		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	351,368					11.00
13.00	01300	NURSING ADMINISTRATION	1,759	695,273				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	15,206	0	666,171			14.00
15.00	01500	PHARMACY	39,554	0	0	767,392		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,112	0	0	0	93,439	16.00
17.00	01700	SOCIAL SERVICE	5,052	0	0	57	0	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	3,355	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	56,059	317,142	59,243	2,339	11,356	30.00
31.00	03100	INTENSIVE CARE UNIT	16,134	72,090	35,224	1,082	2,471	31.00
40.00	04000	SUBPROVIDER - IPF	0	45,413	942	23	580	40.00
43.00	04300	NURSERY	12,774	7,824	0	0	19	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	1,278	4,432	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,502	53,478	220,922	2,696	8,511	50.00
51.00	05100	RECOVERY ROOM	820	7,611	935	127	883	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	50,092	7,978	173	1,124	52.00
52.01	05201	PERINATAL CLINIC	4,293	1,968	282	0	398	52.01
53.00	05300	ANESTHESIOLOGY	0	1,551	16,862	199	2,345	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	33,183	9,783	92,408	739	5,126	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	12,558	1,715	486	0	3,117	55.00
56.00	05600	RADIOISOTOPE	2,667	0	189	16	637	56.00
57.00	05700	CT SCAN	9,319	1	5,402	210	4,949	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,834	4	487	12	1,426	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,719	8,657	136,175	516	3,312	59.00
60.00	06000	LABORATORY	22,281	0	609	0	6,009	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	5,022	0	1	0	723	62.00
64.00	06400	INTRAVENOUS THERAPY	634	12,090	7,465	51	1,076	64.00
65.00	06500	RESPIRATORY THERAPY	25,713	0	8,604	28	1,796	65.00
66.00	06600	PHYSICAL THERAPY	0	0	388	0	455	66.00
66.01	06601	CLINICAL NUTRITION	9,594	0	2	0	14	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	469	0	217	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	16	0	156	68.00
69.00	06900	ELECTROCARDIOLOGY	9,326	21,485	18,636	35	5,002	69.00
69.01	06901	CARDIAC REHABILITATION	101	2,591	102	4	68	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	612	1,636	0	523	70.00
70.01	07001	ELECTROSHOCK THERAPY	4	952	354	0	64	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,810	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,620	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	730,646	17,173	73.00
74.00	07400	RENAL DIALYSIS	0	0	1,048	118	457	74.00
76.00	03330	ENDOSCOPY	476	8,513	13,450	142	1,066	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	15,190	5,332	2,291	23,040	1,626	90.00
91.00	09100	EMERGENCY	8,498	65,602	32,285	707	6,330	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)	348,739	694,506	666,169	767,392	93,439	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,469	19	0	0	0	190.00
191.00	19100	RESEARCH	0	723	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	NON-REIMBURSABLE	1,160	25	2	0	0	194.00
194.01	07950	OTHER	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	0	0	0	0	0	194.03
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)	351,368	695,273	666,171	767,392	93,439	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/28/2019 12:59 pm

		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	37,383					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	51,674				21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0		1,400			22.00
23.00	02300	PHARMACY RESIDENCY PROGRAM	0			21,697		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,976				4,689,787	30.00
31.00	03100	INTENSIVE CARE UNIT	4,992				914,904	31.00
40.00	04000	SUBPROVIDER - IPF	2,112				624,664	40.00
43.00	04300	NURSERY	761				173,983	43.00
44.00	04400	SKILLED NURSING FACILITY	0				145,191	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0				4,117,922	50.00
51.00	05100	RECOVERY ROOM	0				78,860	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	542				228,569	52.00
52.01	05201	PERINATAL CLINIC	0				338,049	52.01
53.00	05300	ANESTHESIOLOGY	0				418,977	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0				1,043,297	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0				2,485,343	55.00
56.00	05600	RADIOISOTOPE	0				363,287	56.00
57.00	05700	CT SCAN	0				195,304	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0				963,972	58.00
59.00	05900	CARDIAC CATHETERIZATION	0				433,612	59.00
60.00	06000	LABORATORY	0				271,423	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0				426,999	62.00
64.00	06400	INTRAVENOUS THERAPY	0				417,687	64.00
65.00	06500	RESPIRATORY THERAPY	0				362,487	65.00
66.00	06600	PHYSICAL THERAPY	0				176,489	66.00
66.01	06601	CLINICAL NUTRITION	0				152,156	66.01
67.00	06700	OCCUPATIONAL THERAPY	0				18,070	67.00
68.00	06800	SPEECH PATHOLOGY	0				77,924	68.00
69.00	06900	ELECTROCARDIOLOGY	0				703,330	69.00
69.01	06901	CARDIAC REHABILITATION	0				22,170	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0				260,574	70.00
70.01	07001	ELECTROSHOCK THERAPY	0				16,208	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0				495,205	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0				421,072	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0				1,437,159	73.00
74.00	07400	RENAL DIALYSIS	0				39,796	74.00
76.00	03330	ENDOSCOPY	0				462,546	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0				1,496,877	90.00
91.00	09100	EMERGENCY	0				1,089,123	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)	37,383	0	0	0	25,563,016	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0				32,966	190.00
191.00	19100	RESEARCH	0				2,848	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0				16,427	192.00
194.00	07951	NON-REIMBURSABLE	0				16,159	194.00
194.01	07950	OTHER	0				0	194.01
194.02	07952	OTHER NONREIMBURSABLE	0				0	194.02
194.03	07953	RETAIL PHARMACY	0				240,791	194.03
200.00		Cross Foot Adjustments		51,674	1,400	21,697	74,771	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	37,383	51,674	1,400	21,697	25,946,978	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/28/2019 12:59 pm

		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	4,689,787		30.00
31.00	03100	INTENSIVE CARE UNIT	0	914,904		31.00
40.00	04000	SUBPROVIDER - IPF	0	624,664		40.00
43.00	04300	NURSERY	0	173,983		43.00
44.00	04400	SKILLED NURSING FACILITY	0	145,191		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	4,117,922		50.00
51.00	05100	RECOVERY ROOM	0	78,860		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	228,569		52.00
52.01	05201	PERINATAL CLINIC	0	338,049		52.01
53.00	05300	ANESTHESIOLOGY	0	418,977		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,043,297		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,485,343		55.00
56.00	05600	RADIOISOTOPE	0	363,287		56.00
57.00	05700	CT SCAN	0	195,304		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	963,972		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	433,612		59.00
60.00	06000	LABORATORY	0	271,423		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	426,999		62.00
64.00	06400	INTRAVENOUS THERAPY	0	417,687		64.00
65.00	06500	RESPIRATORY THERAPY	0	362,487		65.00
66.00	06600	PHYSICAL THERAPY	0	176,489		66.00
66.01	06601	CLINICAL NUTRITION	0	152,156		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	18,070		67.00
68.00	06800	SPEECH PATHOLOGY	0	77,924		68.00
69.00	06900	ELECTROCARDIOLOGY	0	703,330		69.00
69.01	06901	CARDIAC REHABILITATION	0	22,170		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	260,574		70.00
70.01	07001	ELECTROSHOCK THERAPY	0	16,208		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	495,205		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	421,072		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,437,159		73.00
74.00	07400	RENAL DIALYSIS	0	39,796		74.00
76.00	03330	ENDOSCOPY	0	462,546		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	1,496,877		90.00
91.00	09100	EMERGENCY	0	1,089,123		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	25,563,016		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	32,966		190.00
191.00	19100	RESEARCH	0	2,848		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	16,427		192.00
194.00	07951	NON-REIMBURSABLE	0	16,159		194.00
194.01	07950	OTHER	0	0		194.01
194.02	07952	OTHER NONREIMBURSABLE	0	0		194.02
194.03	07953	RETAIL PHARMACY	0	240,791		194.03
200.00		Cross Foot Adjustments	0	74,771		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	25,946,978		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 12:59 pm

		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	703,319					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		6,328,906				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,923	0	125,117,451			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	117,860	277,048	12,114,333	-86,831,124	294,499,075	5.00
7.00	00700	OPERATION OF PLANT	64,030	527,906	1,729,679	0	11,218,437	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,202	0	136,564	0	1,128,542	8.00
9.00	00900	HOUSEKEEPING	1,711	16,690	2,744,066	0	4,875,818	9.00
10.00	01000	DIETARY	17,407	81,842	2,513,287	0	6,502,294	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	6,620	424,438	2,425,110	0	4,270,151	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	19,306	146,142	704,133	0	3,192,082	14.00
15.00	01500	PHARMACY	2,854	11,341	5,018,371	0	7,625,641	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,408	1,962	386,523	0	712,893	16.00
17.00	01700	SOCIAL SERVICE	1,200	0	466,778	0	688,209	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	974,556	0	1,174,365	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	72,220	22.00
23.00	02300	PHARMACY RESIDENCY PROGRAM	538	0	373,929	0	464,802	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	174,422	341,325	37,064,158	0	47,843,393	30.00
31.00	03100	INTENSIVE CARE UNIT	21,319	170,078	8,654,150	0	11,331,002	31.00
40.00	04000	SUBPROVIDER - IPF	32,164	26,004	1,900,524	0	1,568,929	40.00
43.00	04300	NURSERY	7,090	0	1,251,684	0	1,804,871	43.00
44.00	04400	SKILLED NURSING FACILITY	0	48,624	0	0	4,202,417	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	60,646	767,954	8,448,350	0	16,756,357	50.00
51.00	05100	RECOVERY ROOM	0	35,162	1,021,247	0	1,293,380	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	90,414	2,001,241	0	2,432,203	52.00
52.01	05201	PERINATAL CLINIC	8,899	24,110	622,431	0	983,606	52.01
53.00	05300	ANESTHESIOLOGY	15,279	28,139	76,641	0	893,055	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	895	446,914	3,480,826	0	7,851,538	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	24,272	1,113,965	2,150,671	0	5,000,114	55.00
56.00	05600	RADIOISOTOPE	15,374	75,861	297,887	0	1,462,831	56.00
57.00	05700	CT SCAN	1,522	87,555	841,601	0	1,490,182	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	779,269	349,703	0	1,453,930	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,783	151,868	1,318,989	0	2,210,605	59.00
60.00	06000	LABORATORY	7,762	33,421	1,979,117	0	3,513,639	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	22,605	3,629	433,022	0	3,233,423	62.00
64.00	06400	INTRAVENOUS THERAPY	831	15,381	1,849,076	0	2,662,823	64.00
65.00	06500	RESPIRATORY THERAPY	0	118,116	2,276,044	0	3,902,513	65.00
66.00	06600	PHYSICAL THERAPY	8,108	0	0	0	2,502,146	66.00
66.01	06601	CLINICAL NUTRITION	7,988	0	711,686	0	887,660	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	896,613	67.00
68.00	06800	SPEECH PATHOLOGY	4,265	1,003	0	0	502,529	68.00
69.00	06900	ELECTROCARDIOLOGY	99	180,836	2,733,833	0	4,174,652	69.00
69.01	06901	CARDIAC REHABILITATION	0	9,728	313,564	0	392,445	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	10,506	67,366	306,713	0	658,929	70.00
70.01	07001	ELECTROSHOCK THERAPY	688	1,367	91,911	0	123,763	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	25,448,486	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	21,583,048	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	35,554,963	73.00
74.00	07400	RENAL DIALYSIS	0	1,774	0	0	1,841,779	74.00
76.00	03330	ENDOSCOPY	1,482	58,605	981,821	0	1,752,151	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,126	3,391	5,815,224	0	9,844,098	90.00
91.00	09100	EMERGENCY	26,079	151,846	8,349,127	0	11,707,436	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)	700,263	6,321,074	124,908,570	-86,831,124	281,686,963	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,685	1,436	56,101	0	172,869	190.00
191.00	19100	RESEARCH	0	0	89,842	0	108,267	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,033	0	0	0	12,647	192.00
194.00	07951	NON-REIMBURSABLE	338	6,396	62,938	0	98,756	194.00
194.01	07950	OTHER	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	0	0	0	0	12,419,573	194.03
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 12:59 pm

	Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00	4.00	5A	5.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	8,610,837	7,549,967	25,659,705		86,831,124	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	12.243146	1.192934	0.205085		0.294843	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			35,787		5,709,635	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000286		0.019388	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 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 12:59 pm

		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	518,506					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,202	642,367				8.00
9.00	00900	HOUSEKEEPING	1,711	0	514,593			9.00
10.00	01000	DIETARY	17,407	0	17,407	1,110,941		10.00
11.00	01100	CAFETERIA	0	0	0	747,983	676,999	11.00
13.00	01300	NURSING ADMINISTRATION	6,620	0	6,620	0	3,390	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	19,306	0	19,306	0	29,298	14.00
15.00	01500	PHARMACY	2,854	0	2,854	0	76,211	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,408	0	4,408	0	15,629	16.00
17.00	01700	SOCIAL SERVICE	1,200	0	1,200	0	9,734	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	538	0	538	0	6,465	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	174,422	44,302	174,422	281,323	108,011	30.00
31.00	03100	INTENSIVE CARE UNIT	21,319	12,940	21,319	48,469	31,086	31.00
40.00	04000	SUBPROVIDER - IPF	32,164	0	32,164	20,511	0	40.00
43.00	04300	NURSERY	7,090	31,280	7,090	7,390	24,612	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	47,210	50.00
51.00	05100	RECOVERY ROOM	0	13,468	0	0	1,579	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	122,023	0	5,265	0	52.00
52.01	05201	PERINATAL CLINIC	8,899	6,900	8,899	0	8,271	52.01
53.00	05300	ANESTHESIOLOGY	15,279	1,534	15,279	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	895	83,050	895	0	63,936	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	24,272	4,448	24,272	0	24,197	55.00
56.00	05600	RADIOISOTOPE	15,374	0	15,374	0	5,138	56.00
57.00	05700	CT SCAN	1,522	0	1,522	0	17,955	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,500	0	0	7,387	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,783	3,416	2,783	0	5,239	59.00
60.00	06000	LABORATORY	7,762	17,468	7,762	0	42,930	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	22,605	0	22,605	0	9,676	62.00
64.00	06400	INTRAVENOUS THERAPY	831	1,708	831	0	1,221	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	49,543	65.00
66.00	06600	PHYSICAL THERAPY	8,108	1,400	8,108	0	0	66.00
66.01	06601	CLINICAL NUTRITION	7,988	0	7,988	0	18,486	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,265	0	4,265	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	99	20,586	99	0	17,969	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	195	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	10,506	0	10,506	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	688	0	688	0	8	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	4,014	0	0	0	74.00
76.00	03330	ENDOSCOPY	1,482	19,252	1,482	0	918	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,126	0	4,126	0	29,267	90.00
91.00	09100	EMERGENCY	26,079	80,386	26,079	0	16,373	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)	515,450	641,055	511,537	1,110,941	671,934	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,685	0	1,685	0	2,830	190.00
191.00	19100	RESEARCH	0	0	0	0	0	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	2,235	194.00
194.01	07950	OTHER	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	0	0	0	0	0	194.03
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)	14,526,115	1,522,975	6,361,353	9,122,297	6,141,931	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 12:59 pm

		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	
203.00		Unit cost multiplier (Wkst. B, Part I)	28.015327	2.370880	12.361911	8.211324	9.072290	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,631,684	55,807	141,559	521,869	351,368	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.146895	0.086877	0.275089	0.469754	0.519008	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 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 12:59 pm

		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	1,776,737					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	26,680,324				14.00
15.00	01500	PHARMACY	0	0	37,118,029			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,542,017,217		16.00
17.00	01700	SOCIAL SERVICE	0	0	2,756	0	112,034	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	810,440	2,372,664	113,145	186,171,232	86,836	30.00
31.00	03100	INTENSIVE CARE UNIT	184,222	1,410,697	52,339	40,503,012	14,961	31.00
40.00	04000	SUBPROVIDER - IPF	116,052	37,729	1,131	9,508,677	6,331	40.00
43.00	04300	NURSERY	19,994	0	0	317,523	2,281	43.00
44.00	04400	SKILLED NURSING FACILITY	0	51,199	214,366	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	136,661	8,848,261	130,413	139,526,153	0	50.00
51.00	05100	RECOVERY ROOM	19,450	37,429	6,125	14,471,822	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	128,009	319,523	8,391	18,432,426	1,625	52.00
52.01	05201	PERINATAL CLINIC	5,028	11,308	0	6,523,771	0	52.01
53.00	05300	ANESTHESIOLOGY	3,963	675,298	9,625	38,441,483	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,000	3,700,890	35,764	84,030,174	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,382	19,453	1	51,096,486	0	55.00
56.00	05600	RADIOISOTOPE	0	7,568	786	10,444,903	0	56.00
57.00	05700	CT SCAN	2	216,333	10,150	81,129,924	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	9	19,500	563	23,373,676	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	22,122	5,453,754	24,980	54,287,628	0	59.00
60.00	06000	LABORATORY	0	24,404	0	98,503,500	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1	49	0	11,851,596	0	62.00
64.00	06400	INTRAVENOUS THERAPY	30,896	298,960	2,449	17,638,698	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	344,599	1,357	29,441,141	0	65.00
66.00	06600	PHYSICAL THERAPY	0	15,527	0	7,464,930	0	66.00
66.01	06601	CLINICAL NUTRITION	0	85	0	236,599	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	18,786	0	3,557,377	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	633	0	2,553,388	0	68.00
69.00	06900	ELECTROCARDIOLOGY	54,905	746,347	1,669	81,999,237	0	69.00
69.01	06901	CARDIAC REHABILITATION	6,621	4,105	177	1,107,465	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	1,564	65,539	6	8,579,607	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	2,434	14,187	4	1,041,786	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	29,675,359	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	42,953,354	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	35,340,597	291,755,556	0	73.00
74.00	07400	RENAL DIALYSIS	0	41,984	5,702	7,492,934	0	74.00
76.00	03330	ENDOSCOPY	21,755	538,667	6,865	17,470,601	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	13,626	91,769	1,114,461	26,663,721	0	90.00
91.00	09100	EMERGENCY	167,642	1,292,997	34,207	103,771,478	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)	1,774,778	26,680,244	37,118,029	1,542,017,217	112,034	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	49	0	0	0	0	190.00
191.00	19100	RESEARCH	1,847	7	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	NON-REIMBURSABLE	63	73	0	0	0	194.00
194.01	07950	OTHER	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 12:59 pm

		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	
202.00		Cost to be allocated (per Wkst. B, Part I)	5,827,227	5,178,568	10,680,653	1,242,859	1,028,678	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.279735	0.194097	0.287748	0.000806	9.181838	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	695,273	666,171	767,392	93,439	37,383	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.391320	0.024969	0.020674	0.000061	0.333675	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 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 12:59 pm

		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	914				21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD		914			22.00
23.00	02300	PHARMACY RESIDENCY PROGRAM			1,008		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	808	808	189		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	252		31.00
40.00	04000	SUBPROVIDER - IPF	0	0	189		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	46	46	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	189		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	20	20	189		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)	914	914	1,008		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	OTHER	0	0	0		194.01
194.02	07952	OTHER NONREIMBURSABLE	0	0	0		194.02
194.03	07953	RETAIL PHARMACY	0	0	0		194.03
200.00		Cross Foot Adjustments					200.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 12:59 pm

	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		
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,520,618	93,514	682,221		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1,663.695842	102.312910	676.806548		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	51,674	1,400	21,697		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	56.536105	1.531729	21.524802		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 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/28/2019 12:59 pm

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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	76,613,859		76,613,859	46,623	76,660,482	30.00
31.00	03100	INTENSIVE CARE UNIT	17,477,009		17,477,009	0	17,477,009	31.00
40.00	04000	SUBPROVIDER - IPF	4,080,611		4,080,611	0	4,080,611	40.00
43.00	04300	NURSERY	3,068,205		3,068,205	0	3,068,205	43.00
44.00	04400	SKILLED NURSING FACILITY	5,513,091		5,513,091	0	5,513,091	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,291,063		27,291,063	11,322	27,302,385	50.00
51.00	05100	RECOVERY ROOM	1,805,462		1,805,462	0	1,805,462	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,995,901		3,995,901	0	3,995,901	52.00
52.01	05201	PERINATAL CLINIC	1,748,272		1,748,272	0	1,748,272	52.01
53.00	05300	ANESTHESIOLOGY	1,954,752		1,954,752	42,581	1,997,333	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,857,939		11,857,939	0	11,857,939	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	7,743,799		7,743,799	0	7,743,799	55.00
56.00	05600	RADIOISOTOPE	2,571,623		2,571,623	0	2,571,623	56.00
57.00	05700	CT SCAN	2,264,208		2,264,208	0	2,264,208	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,980,742		1,980,742	0	1,980,742	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,212,440		4,212,440	0	4,212,440	59.00
60.00	06000	LABORATORY	5,378,038		5,378,038	0	5,378,038	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	5,196,850		5,196,850	0	5,196,850	62.00
64.00	06400	INTRAVENOUS THERAPY	3,670,898		3,670,898	0	3,670,898	64.00
65.00	06500	RESPIRATORY THERAPY	5,593,616	0	5,593,616	12,048	5,605,664	65.00
66.00	06600	PHYSICAL THERAPY	3,579,614	0	3,579,614	0	3,579,614	66.00
66.01	06601	CLINICAL NUTRITION	1,639,830	0	1,639,830	0	1,639,830	66.01
67.00	06700	OCCUPATIONAL THERAPY	1,167,486	0	1,167,486	0	1,167,486	67.00
68.00	06800	SPEECH PATHOLOGY	825,086	0	825,086	0	825,086	68.00
69.00	06900	ELECTROCARDIOLOGY	6,140,769		6,140,769	0	6,140,769	69.00
69.01	06901	CARDIAC REHABILITATION	533,380		533,380	3,313	536,693	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	1,302,181		1,302,181	3,616	1,305,797	70.00
70.01	07001	ELECTROSHOCK THERAPY	199,685		199,685	0	199,685	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	32,975,712		32,975,712	0	32,975,712	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,981,279		27,981,279	0	27,981,279	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	56,442,446		56,442,446	0	56,442,446	73.00
74.00	07400	RENAL DIALYSIS	2,410,161		2,410,161	0	2,410,161	74.00
76.00	03330	ENDOSCOPY	2,574,532		2,574,532	0	2,574,532	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	13,583,353		13,583,353	11,763	13,595,116	90.00
91.00	09100	EMERGENCY	17,573,604		17,573,604	0	17,573,604	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,346,951		6,346,951		6,346,951	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	369,294,447	0	369,294,447	131,266	369,425,713	200.00
201.00		Less Observation Beds	6,346,951		6,346,951		6,346,951	201.00
202.00		Total (see instructions)	362,947,496	0	362,947,496	131,266	363,078,762	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I | Date/Time Prepared: 5/28/2019 12:59 pm

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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	179,595,056		179,595,056			30.00
31.00	03100	INTENSIVE CARE UNIT	45,860,567		45,860,567			31.00
40.00	04000	SUBPROVIDER - IPF	10,938,508		10,938,508			40.00
43.00	04300	NURSERY	2,864,283		2,864,283			43.00
44.00	04400	SKILLED NURSING FACILITY	4,303,671		4,303,671			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	64,542,773	65,640,283	130,183,056	0.209636	0.000000	50.00
51.00	05100	RECOVERY ROOM	8,544,347	5,082,806	13,627,153	0.132490	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,538,012	4,602,642	18,140,654	0.220273	0.000000	52.00
52.01	05201	PERINATAL CLINIC	75,025	5,870,350	5,945,375	0.294056	0.000000	52.01
53.00	05300	ANESTHESIOLOGY	16,303,707	19,983,155	36,286,862	0.053869	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,107,817	53,629,419	79,737,236	0.148713	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,145,679	48,218,661	49,364,340	0.156870	0.000000	55.00
56.00	05600	RADIOISOTOPE	5,001,144	5,046,761	10,047,905	0.255936	0.000000	56.00
57.00	05700	CT SCAN	33,197,455	45,242,692	78,440,147	0.028865	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,779,127	15,216,847	21,995,974	0.090050	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	31,588,378	21,105,402	52,693,780	0.079942	0.000000	59.00
60.00	06000	LABORATORY	62,076,716	33,323,422	95,400,138	0.056373	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	8,991,073	2,510,580	11,501,653	0.451835	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	939,653	15,910,852	16,850,505	0.217851	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	21,574,715	6,901,037	28,475,752	0.196434	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	6,351,032	903,725	7,254,757	0.493416	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	214	216,566	216,780	7.564489	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	2,904,899	571,331	3,476,230	0.335848	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,236,094	267,945	2,504,039	0.329502	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	29,894,430	49,291,081	79,185,511	0.077549	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	138,369	930,071	1,068,440	0.499214	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	3,920,682	4,207,823	8,128,505	0.160199	0.000000	70.00
70.01	07001	ELECTROSHOCK THERAPY	222,938	709,690	932,628	0.214110	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	19,292,521	9,913,098	29,205,619	1.129088	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,631,137	11,642,297	42,273,434	0.661912	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68,688,369	218,448,911	287,137,280	0.196570	0.000000	73.00
74.00	07400	RENAL DIALYSIS	6,803,660	549,125	7,352,785	0.327789	0.000000	74.00
76.00	03330	ENDOSCOPY	3,893,554	12,509,752	16,403,306	0.156952	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	88,992	25,987,728	26,076,720	0.520900	0.000000	90.00
91.00	09100	EMERGENCY	44,331,792	56,066,431	100,398,223	0.175039	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,713,436	20,695,560	24,408,996	0.260025	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	767,079,825	761,196,043	1,528,275,868			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	767,079,825	761,196,043	1,528,275,868			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/28/2019 12:59 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
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	0.209723		50.00
51.00	05100	RECOVERY ROOM	0.132490		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.220273		52.00
52.01	05201	PERINATAL CLINIC	0.294056		52.01
53.00	05300	ANESTHESIOLOGY	0.055043		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148713		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.156870		55.00
56.00	05600	RADIOISOTOPE	0.255936		56.00
57.00	05700	CT SCAN	0.028865		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.090050		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.079942		59.00
60.00	06000	LABORATORY	0.056373		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.451835		62.00
64.00	06400	INTRAVENOUS THERAPY	0.217851		64.00
65.00	06500	RESPIRATORY THERAPY	0.196857		65.00
66.00	06600	PHYSICAL THERAPY	0.493416		66.00
66.01	06601	CLINICAL NUTRITION	7.564489		66.01
67.00	06700	OCCUPATIONAL THERAPY	0.335848		67.00
68.00	06800	SPEECH PATHOLOGY	0.329502		68.00
69.00	06900	ELECTROCARDIOLOGY	0.077549		69.00
69.01	06901	CARDIAC REHABILITATION	0.502315		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.160644		70.00
70.01	07001	ELECTROSHOCK THERAPY	0.214110		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.129088		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.661912		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.196570		73.00
74.00	07400	RENAL DIALYSIS	0.327789		74.00
76.00	03330	ENDOSCOPY	0.156952		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.521351		90.00
91.00	09100	EMERGENCY	0.175039		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.260025		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 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/28/2019 12:59 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	76,613,859		76,613,859	46,623	76,660,482	30.00
31.00	03100	INTENSIVE CARE UNIT	17,477,009		17,477,009	0	17,477,009	31.00
40.00	04000	SUBPROVIDER - IPF	4,080,611		4,080,611	0	4,080,611	40.00
43.00	04300	NURSERY	3,068,205		3,068,205	0	3,068,205	43.00
44.00	04400	SKILLED NURSING FACILITY	5,513,091		5,513,091	0	5,513,091	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,291,063		27,291,063	11,322	27,302,385	50.00
51.00	05100	RECOVERY ROOM	1,805,462		1,805,462	0	1,805,462	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,995,901		3,995,901	0	3,995,901	52.00
52.01	05201	PERINATAL CLINIC	1,748,272		1,748,272	0	1,748,272	52.01
53.00	05300	ANESTHESIOLOGY	1,954,752		1,954,752	42,581	1,997,333	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,857,939		11,857,939	0	11,857,939	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	7,743,799		7,743,799	0	7,743,799	55.00
56.00	05600	RADIOISOTOPE	2,571,623		2,571,623	0	2,571,623	56.00
57.00	05700	CT SCAN	2,264,208		2,264,208	0	2,264,208	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,980,742		1,980,742	0	1,980,742	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,212,440		4,212,440	0	4,212,440	59.00
60.00	06000	LABORATORY	5,378,038		5,378,038	0	5,378,038	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	5,196,850		5,196,850	0	5,196,850	62.00
64.00	06400	INTRAVENOUS THERAPY	3,670,898		3,670,898	0	3,670,898	64.00
65.00	06500	RESPIRATORY THERAPY	5,593,616	0	5,593,616	12,048	5,605,664	65.00
66.00	06600	PHYSICAL THERAPY	3,579,614	0	3,579,614	0	3,579,614	66.00
66.01	06601	CLINICAL NUTRITION	1,639,830	0	1,639,830	0	1,639,830	66.01
67.00	06700	OCCUPATIONAL THERAPY	1,167,486	0	1,167,486	0	1,167,486	67.00
68.00	06800	SPEECH PATHOLOGY	825,086	0	825,086	0	825,086	68.00
69.00	06900	ELECTROCARDIOLOGY	6,140,769		6,140,769	0	6,140,769	69.00
69.01	06901	CARDIAC REHABILITATION	533,380		533,380	3,313	536,693	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	1,302,181		1,302,181	3,616	1,305,797	70.00
70.01	07001	ELECTROSHOCK THERAPY	199,685		199,685	0	199,685	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	32,975,712		32,975,712	0	32,975,712	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,981,279		27,981,279	0	27,981,279	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	56,442,446		56,442,446	0	56,442,446	73.00
74.00	07400	RENAL DIALYSIS	2,410,161		2,410,161	0	2,410,161	74.00
76.00	03330	ENDOSCOPY	2,574,532		2,574,532	0	2,574,532	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	13,583,353		13,583,353	11,763	13,595,116	90.00
91.00	09100	EMERGENCY	17,573,604		17,573,604	0	17,573,604	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,346,951		6,346,951		6,346,951	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	369,294,447	0	369,294,447	131,266	369,425,713	200.00
201.00		Less Observation Beds	6,346,951		6,346,951		6,346,951	201.00
202.00		Total (see instructions)	362,947,496	0	362,947,496	131,266	363,078,762	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/28/2019 12:59 pm

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	179,595,056		179,595,056			30.00
31.00	03100	INTENSIVE CARE UNIT	45,860,567		45,860,567			31.00
40.00	04000	SUBPROVIDER - IPF	10,938,508		10,938,508			40.00
43.00	04300	NURSERY	2,864,283		2,864,283			43.00
44.00	04400	SKILLED NURSING FACILITY	4,303,671		4,303,671			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	64,542,773	65,640,283	130,183,056	0.209636	0.000000	50.00
51.00	05100	RECOVERY ROOM	8,544,347	5,082,806	13,627,153	0.132490	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,538,012	4,602,642	18,140,654	0.220273	0.000000	52.00
52.01	05201	PERINATAL CLINIC	75,025	5,870,350	5,945,375	0.294056	0.000000	52.01
53.00	05300	ANESTHESIOLOGY	16,303,707	19,983,155	36,286,862	0.053869	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,107,817	53,629,419	79,737,236	0.148713	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,145,679	48,218,661	49,364,340	0.156870	0.000000	55.00
56.00	05600	RADIOISOTOPE	5,001,144	5,046,761	10,047,905	0.255936	0.000000	56.00
57.00	05700	CT SCAN	33,197,455	45,242,692	78,440,147	0.028865	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,779,127	15,216,847	21,995,974	0.090050	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	31,588,378	21,105,402	52,693,780	0.079942	0.000000	59.00
60.00	06000	LABORATORY	62,076,716	33,323,422	95,400,138	0.056373	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	8,991,073	2,510,580	11,501,653	0.451835	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	939,653	15,910,852	16,850,505	0.217851	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	21,574,715	6,901,037	28,475,752	0.196434	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	6,351,032	903,725	7,254,757	0.493416	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	214	216,566	216,780	7.564489	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	2,904,899	571,331	3,476,230	0.335848	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,236,094	267,945	2,504,039	0.329502	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	29,894,430	49,291,081	79,185,511	0.077549	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	138,369	930,071	1,068,440	0.499214	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	3,920,682	4,207,823	8,128,505	0.160199	0.000000	70.00
70.01	07001	ELECTROSHOCK THERAPY	222,938	709,690	932,628	0.214110	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	19,292,521	9,913,098	29,205,619	1.129088	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,631,137	11,642,297	42,273,434	0.661912	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68,688,369	218,448,911	287,137,280	0.196570	0.000000	73.00
74.00	07400	RENAL DIALYSIS	6,803,660	549,125	7,352,785	0.327789	0.000000	74.00
76.00	03330	ENDOSCOPY	3,893,554	12,509,752	16,403,306	0.156952	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	88,992	25,987,728	26,076,720	0.520900	0.000000	90.00
91.00	09100	EMERGENCY	44,331,792	56,066,431	100,398,223	0.175039	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,713,436	20,695,560	24,408,996	0.260025	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	767,079,825	761,196,043	1,528,275,868			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	767,079,825	761,196,043	1,528,275,868			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/28/2019 12:59 pm

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 01/01/2018 To 12/31/2018 | Worksheet D Part I Date/Time Prepared: 5/28/2019 12:59 pm

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	4,689,787	0	4,689,787	95,986	48.86	30.00
31.00	INTENSIVE CARE UNIT	914,904		914,904	14,961	61.15	31.00
40.00	SUBPROVIDER - IPF	624,664	0	624,664	6,331	98.67	40.00
43.00	NURSERY	173,983		173,983	2,281	76.27	43.00
44.00	SKILLED NURSING FACILITY	145,191		145,191	16,980	8.55	44.00
200.00	Total (lines 30 through 199)	6,548,529		6,548,529	136,539		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	27,233	1,330,604				30.00
31.00	INTENSIVE CARE UNIT	1,953	119,426				31.00
40.00	SUBPROVIDER - IPF	2,803	276,572				40.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	3,466	29,634				44.00
200.00	Total (lines 30 through 199)	35,455	1,756,236				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/28/2019 12:59 pm

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	4,117,922	130,183,056	0.031632	28,466,944	900,466	50.00
51.00	05100	RECOVERY ROOM	78,860	13,627,153	0.005787	2,606,067	15,081	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	228,569	18,140,654	0.012600	23,996	302	52.00
52.01	05201	PERINATAL CLINIC	338,049	5,945,375	0.056859	0	0	52.01
53.00	05300	ANESTHESIOLOGY	418,977	36,286,862	0.011546	4,295,498	49,596	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,043,297	79,737,236	0.013084	6,530,346	85,443	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,485,343	49,364,340	0.050347	542,963	27,337	55.00
56.00	05600	RADIOISOTOPE	363,287	10,047,905	0.036155	1,761,883	63,701	56.00
57.00	05700	CT SCAN	195,304	78,440,147	0.002490	11,361,513	28,290	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	963,972	21,995,974	0.043825	2,366,857	103,728	58.00
59.00	05900	CARDIAC CATHETERIZATION	433,612	52,693,780	0.008229	6,725,533	55,344	59.00
60.00	06000	LABORATORY	271,423	95,400,138	0.002845	21,569,505	61,365	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	426,999	11,501,653	0.037125	1,991,616	73,939	62.00
64.00	06400	INTRAVENOUS THERAPY	417,687	16,850,505	0.024788	17,890	443	64.00
65.00	06500	RESPIRATORY THERAPY	362,487	28,475,752	0.012730	6,786,675	86,394	65.00
66.00	06600	PHYSICAL THERAPY	176,489	7,254,757	0.024327	2,254,520	54,846	66.00
66.01	06601	CLINICAL NUTRITION	152,156	216,780	0.701891	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	18,070	3,476,230	0.005198	982,512	5,107	67.00
68.00	06800	SPEECH PATHOLOGY	77,924	2,504,039	0.031119	932,637	29,023	68.00
69.00	06900	ELECTROCARDIOLOGY	703,330	79,185,511	0.008882	9,952,267	88,396	69.00
69.01	06901	CARDIAC REHABILITATION	22,170	1,068,440	0.020750	22,770	472	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	260,574	8,128,505	0.032057	1,281,060	41,067	70.00
70.01	07001	ELECTROSHOCK THERAPY	16,208	932,628	0.017379	2,686	47	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	495,205	29,205,619	0.016956	7,366,315	124,903	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	421,072	42,273,434	0.009961	10,652,874	106,113	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,437,159	287,137,280	0.005005	22,246,202	111,342	73.00
74.00	07400	RENAL DIALYSIS	39,796	7,352,785	0.005412	3,871,556	20,953	74.00
76.00	03330	ENDOSCOPY	462,546	16,403,306	0.028198	1,115,040	31,442	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,496,877	26,076,720	0.057403	366	21	90.00
91.00	09100	EMERGENCY	1,089,123	100,398,223	0.010848	11,473,799	124,468	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	388,281	24,408,996	0.015907	2,370,531	37,708	92.00
200.00		Total (lines 50 through 199)	19,402,768	1,284,713,783		169,572,421	2,327,337	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part III Date/Time Prepared: 5/28/2019 12:59 pm

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	127,916	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	170,557	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	127,916	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	426,389	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	127,916	95,986	1.33	27,233	30.00
31.00	03100	INTENSIVE CARE UNIT		170,557	14,961	11.40	1,953	31.00
40.00	04000	SUBPROVIDER - IPF	0	127,916	6,331	20.20	2,803	40.00
43.00	04300	NURSERY		0	2,281	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	16,980	0.00	3,466	44.00
200.00		Total (lines 30 through 199)		426,389	136,539		35,455	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	36,220					30.00
31.00	03100	INTENSIVE CARE UNIT	22,264					31.00
40.00	04000	SUBPROVIDER - IPF	56,621					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)	115,105					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/28/2019 12:59 pm

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	127,916	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	127,916	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		10,593	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	266,425	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/28/2019 12:59 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	130,183,056	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	13,627,153	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	18,140,654	0.000000	52.00
52.01	05201	PERINATAL CLINIC	0	0	0	5,945,375	0.000000	52.01
53.00	05300	ANESTHESIOLOGY	0	0	0	36,286,862	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	79,737,236	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	49,364,340	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	10,047,905	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	78,440,147	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	21,995,974	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	52,693,780	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	95,400,138	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	11,501,653	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	16,850,505	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	28,475,752	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,254,757	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	216,780	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,476,230	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,504,039	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	127,916	127,916	79,185,511	0.001615	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	1,068,440	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	8,128,505	0.000000	70.00
70.01	07001	ELECTROSHOCK THERAPY	0	0	0	932,628	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	29,205,619	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	42,273,434	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	287,137,280	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	7,352,785	0.000000	74.00
76.00	03330	ENDOSCOPY	0	0	0	16,403,306	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	26,076,720	0.000000	90.00
91.00	09100	EMERGENCY	0	127,916	127,916	100,398,223	0.001274	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	10,593	10,593	24,408,996	0.000434	92.00
200.00		Total (lines 50 through 199)	0	266,425	266,425	1,284,713,783		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/28/2019 12:59 pm

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	28,466,944	0	35,524,480	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	2,606,067	0	3,122,056	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	23,996	0	8,670	0	52.00
52.01	05201	PERINATAL CLINIC	0.000000	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.000000	4,295,498	0	3,006,828	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	6,530,346	0	9,079,591	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	542,963	0	16,298,710	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	1,761,883	0	1,977,517	0	56.00
57.00	05700	CT SCAN	0.000000	11,361,513	0	8,580,064	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	2,366,857	0	4,303,367	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	6,725,533	0	3,981,829	0	59.00
60.00	06000	LABORATORY	0.000000	21,569,505	0	6,426,904	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	1,991,616	0	230,738	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	17,890	0	2,094,182	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	6,786,675	0	1,229,901	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	2,254,520	0	84,479	0	66.00
66.01	06601	CLINICAL NUTRITION	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	982,512	0	38,603	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	932,637	0	24,865	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.001615	9,952,267	16,073	4,984,656	8,050	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	22,770	0	397,277	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	1,281,060	0	988,363	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.000000	2,686	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	7,366,315	0	3,874,240	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	10,652,874	0	2,479,667	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	22,246,202	0	77,623,226	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	3,871,556	0	313,059	0	74.00
76.00	03330	ENDOSCOPY	0.000000	1,115,040	0	1,904,759	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	366	0	6,941,853	0	90.00
91.00	09100	EMERGENCY	0.001274	11,473,799	14,618	7,233,881	9,216	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000434	2,370,531	1,029	5,150,347	2,235	92.00
200.00		Total (lines 50 through 199)		169,572,421	31,720	207,904,112	19,501	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/28/2019 12:59 pm

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	0.209636	35,524,480	0	0	7,447,210	50.00
51.00	05100	RECOVERY ROOM	0.132490	3,122,056	0	0	413,641	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.220273	8,670	0	0	1,910	52.00
52.01	05201	PERINATAL CLINIC	0.294056	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.053869	3,006,828	0	0	161,975	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148713	9,079,591	0	0	1,350,253	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.156870	16,298,710	0	0	2,556,779	55.00
56.00	05600	RADIOISOTOPE	0.255936	1,977,517	0	0	506,118	56.00
57.00	05700	CT SCAN	0.028865	8,580,064	0	0	247,664	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.090050	4,303,367	0	0	387,518	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.079942	3,981,829	0	0	318,315	59.00
60.00	06000	LABORATORY	0.056373	6,426,904	0	0	362,304	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.451835	230,738	0	0	104,256	62.00
64.00	06400	INTRAVENOUS THERAPY	0.217851	2,094,182	0	0	456,220	64.00
65.00	06500	RESPIRATORY THERAPY	0.196434	1,229,901	0	0	241,594	65.00
66.00	06600	PHYSICAL THERAPY	0.493416	84,479	0	0	41,683	66.00
66.01	06601	CLINICAL NUTRITION	7.564489	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.335848	38,603	0	0	12,965	67.00
68.00	06800	SPEECH PATHOLOGY	0.329502	24,865	0	0	8,193	68.00
69.00	06900	ELECTROCARDIOLOGY	0.077549	4,984,656	0	0	386,555	69.00
69.01	06901	CARDIAC REHABILITATION	0.499214	397,277	0	0	198,326	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.160199	988,363	0	0	158,335	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.214110	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.129088	3,874,240	0	0	4,374,358	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.661912	2,479,667	0	0	1,641,321	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.196570	77,623,226	2,036	383,854	15,258,398	73.00
74.00	07400	RENAL DIALYSIS	0.327789	313,059	0	0	102,617	74.00
76.00	03330	ENDOSCOPY	0.156952	1,904,759	0	0	298,956	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.520900	6,941,853	0	927	3,616,011	90.00
91.00	09100	EMERGENCY	0.175039	7,233,881	0	0	1,266,211	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.260025	5,150,347	0	0	1,339,219	92.00
200.00		Subtotal (see instructions)		207,904,112	2,036	384,781	43,258,905	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		207,904,112	2,036	384,781	43,258,905	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/28/2019 12:59 pm

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	400	75,454		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	483		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)	400	75,937		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	400	75,937		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 26-0104 | Component CCN: 26-S104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/28/2019 12:59 pm

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	4,117,922	130,183,056	0.031632	5,096	161	50.00
51.00	05100	RECOVERY ROOM	78,860	13,627,153	0.005787	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	228,569	18,140,654	0.012600	0	0	52.00
52.01	05201	PERINATAL CLINIC	338,049	5,945,375	0.056859	0	0	52.01
53.00	05300	ANESTHESIOLOGY	418,977	36,286,862	0.011546	8,523	98	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,043,297	79,737,236	0.013084	16,995	222	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,485,343	49,364,340	0.050347	427	21	55.00
56.00	05600	RADIOISOTOPE	363,287	10,047,905	0.036155	0	0	56.00
57.00	05700	CT SCAN	195,304	78,440,147	0.002490	33,600	84	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	963,972	21,995,974	0.043825	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	433,612	52,693,780	0.008229	0	0	59.00
60.00	06000	LABORATORY	271,423	95,400,138	0.002845	565,360	1,608	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	426,999	11,501,653	0.037125	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	417,687	16,850,505	0.024788	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	362,487	28,475,752	0.012730	4,323	55	65.00
66.00	06600	PHYSICAL THERAPY	176,489	7,254,757	0.024327	288	7	66.00
66.01	06601	CLINICAL NUTRITION	152,156	216,780	0.701891	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	18,070	3,476,230	0.005198	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	77,924	2,504,039	0.031119	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	703,330	79,185,511	0.008882	11,038	98	69.00
69.01	06901	CARDIAC REHABILITATION	22,170	1,068,440	0.020750	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	260,574	8,128,505	0.032057	2,768	89	70.00
70.01	07001	ELECTROSHOCK THERAPY	16,208	932,628	0.017379	49,381	858	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	495,205	29,205,619	0.016956	730	12	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	421,072	42,273,434	0.009961	724	7	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,437,159	287,137,280	0.005005	678,943	3,398	73.00
74.00	07400	RENAL DIALYSIS	39,796	7,352,785	0.005412	4,542	25	74.00
76.00	03330	ENDOSCOPY	462,546	16,403,306	0.028198	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,496,877	26,076,720	0.057403	0	0	90.00
91.00	09100	EMERGENCY	1,089,123	100,398,223	0.010848	388,268	4,212	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	24,408,996	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	19,014,487	1,284,713,783		1,771,006	10,955	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0104 | Component CCN: 26-S104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/28/2019 12:59 pm

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	127,916	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	127,916	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	255,832	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0104 | Component CCN: 26-S104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/28/2019 12:59 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	130,183,056	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	13,627,153	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	18,140,654	0.000000	52.00
52.01	05201	PERINATAL CLINIC	0	0	0	5,945,375	0.000000	52.01
53.00	05300	ANESTHESIOLOGY	0	0	0	36,286,862	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	79,737,236	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	49,364,340	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	10,047,905	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	78,440,147	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	21,995,974	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	52,693,780	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	95,400,138	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	11,501,653	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	16,850,505	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	28,475,752	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,254,757	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	216,780	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,476,230	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,504,039	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	127,916	127,916	79,185,511	0.001615	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	1,068,440	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	8,128,505	0.000000	70.00
70.01	07001	ELECTROSHOCK THERAPY	0	0	0	932,628	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	29,205,619	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	42,273,434	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	287,137,280	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	7,352,785	0.000000	74.00
76.00	03330	ENDOSCOPY	0	0	0	16,403,306	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	26,076,720	0.000000	90.00
91.00	09100	EMERGENCY	0	127,916	127,916	100,398,223	0.001274	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	24,408,996	0.000000	92.00
200.00		Total (lines 50 through 199)	0	255,832	255,832	1,284,713,783		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0104 | Component CCN: 26-S104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/28/2019 12:59 pm

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	5,096	0	586	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	8,523	0	32,064	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	16,995	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	427	0	22,968	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	33,600	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	565,360	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	4,323	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	288	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	0.001615	11,038	18	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	2,768	0	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.000000	49,381	0	126,242	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	730	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	724	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	678,943	0	32,530	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	4,542	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	0.001274	388,268	495	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)		1,771,006	513	214,390	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 26-0104 | Component CCN: 26-S104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V | Date/Time Prepared: 5/28/2019 12:59 pm

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	0.209636	586	0	0	123	50.00
51.00	05100	RECOVERY ROOM	0.132490	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.220273	0	0	0	0	52.00
52.01	05201	PERINATAL CLINIC	0.294056	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.053869	32,064	0	0	1,727	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148713	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.156870	22,968	0	0	3,603	55.00
56.00	05600	RADIOISOTOPE	0.255936	0	0	0	0	56.00
57.00	05700	CT SCAN	0.028865	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.090050	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.079942	0	0	0	0	59.00
60.00	06000	LABORATORY	0.056373	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.451835	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.217851	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.196434	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.493416	0	0	0	0	66.00
66.01	06601	CLINICAL NUTRITION	7.564489	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.335848	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.329502	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.077549	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.499214	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.160199	0	0	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.214110	126,242	0	0	27,030	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.129088	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.661912	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.196570	32,530	0	0	6,394	73.00
74.00	07400	RENAL DIALYSIS	0.327789	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	0.156952	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.520900	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.175039	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.260025	0	0	0	0	92.00
200.00		Subtotal (see instructions)		214,390	0	0	38,877	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		214,390	0	0	38,877	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 26-0104 | Component CCN: 26-S104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V | Date/Time Prepared: 5/28/2019 12:59 pm

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 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/28/2019 12:59 pm

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	127,916	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	127,916	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	255,832	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0104 | Component CCN: 26-5842 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/28/2019 12:59 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	130,183,056	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	13,627,153	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	18,140,654	0.000000	52.00
52.01	05201	PERINATAL CLINIC	0	0	0	5,945,375	0.000000	52.01
53.00	05300	ANESTHESIOLOGY	0	0	0	36,286,862	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	79,737,236	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	49,364,340	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	10,047,905	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	78,440,147	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	21,995,974	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	52,693,780	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	95,400,138	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	11,501,653	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	16,850,505	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	28,475,752	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,254,757	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	216,780	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,476,230	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,504,039	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	127,916	127,916	79,185,511	0.001615	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	1,068,440	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	8,128,505	0.000000	70.00
70.01	07001	ELECTROSHOCK THERAPY	0	0	0	932,628	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	29,205,619	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	42,273,434	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	287,137,280	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	7,352,785	0.000000	74.00
76.00	03330	ENDOSCOPY	0	0	0	16,403,306	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	26,076,720	0.000000	90.00
91.00	09100	EMERGENCY	0	127,916	127,916	100,398,223	0.001274	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	24,408,996	0.000000	92.00
200.00		Total (lines 50 through 199)	0	255,832	255,832	1,284,713,783		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0104 | Component CCN: 26-5842 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/28/2019 12:59 pm

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	5,162	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	5,846	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	407,589	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	400,077	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	175,723	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.001615	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	7,459	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	119,169	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	0.001274	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)		1,121,025	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/28/2019 12:59 pm

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	0.209636	3,313,434	0	0	694,615	50.00
51.00	05100	RECOVERY ROOM	0.132490	403,773	0	0	53,496	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.220273	439,548	0	0	96,821	52.00
52.01	05201	PERINATAL CLINIC	0.294056	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.053869	412,207	0	0	22,205	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148713	2,492,747	0	0	370,704	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.156870	3,119,557	0	0	489,365	55.00
56.00	05600	RADIOISOTOPE	0.255936	346,269	0	0	88,623	56.00
57.00	05700	CT SCAN	0.028865	3,321,069	0	0	95,863	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.090050	751,894	0	0	67,708	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.079942	388,419	0	0	31,051	59.00
60.00	06000	LABORATORY	0.056373	3,366,001	0	0	189,752	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.451835	57,231	0	0	25,859	62.00
64.00	06400	INTRAVENOUS THERAPY	0.217851	296,824	0	0	64,663	64.00
65.00	06500	RESPIRATORY THERAPY	0.196434	144,598	0	0	28,404	65.00
66.00	06600	PHYSICAL THERAPY	0.493416	16,007	0	0	7,898	66.00
66.01	06601	CLINICAL NUTRITION	7.564489	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.335848	6,537	0	0	2,195	67.00
68.00	06800	SPEECH PATHOLOGY	0.329502	8,174	0	0	2,693	68.00
69.00	06900	ELECTROCARDIOLOGY	0.077549	1,216,072	0	0	94,305	69.00
69.01	06901	CARDIAC REHABILITATION	0.499214	14,168	0	0	7,073	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.160199	296,609	0	0	47,516	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.214110	103,411	0	0	22,141	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.129088	333,413	0	0	376,453	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.661912	401,695	0	0	265,887	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.196570	12,246,782	0	0	2,407,350	73.00
74.00	07400	RENAL DIALYSIS	0.327789	127,429	0	0	41,770	74.00
76.00	03330	ENDOSCOPY	0.156952	196,779	0	0	30,885	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.520900	858,086	0	0	446,977	90.00
91.00	09100	EMERGENCY	0.175039	6,150,846	0	0	1,076,638	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.260025	1,385,952	0	0	360,382	92.00
200.00		Subtotal (see instructions)		42,215,531	0	0	7,509,292	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		42,215,531	0	0	7,509,292	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/28/2019 12:59 pm

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	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 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/28/2019 12:59 pm

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	127,916	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	127,916	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	255,832	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0104 | Component CCN: 26-5842 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/28/2019 12:59 pm

Title XIX | Skilled Nursing Facility | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	130,183,056	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	13,627,153	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	18,140,654	0.000000	52.00
52.01	05201	PERINATAL CLINIC	0	0	0	5,945,375	0.000000	52.01
53.00	05300	ANESTHESIOLOGY	0	0	0	36,286,862	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	79,737,236	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	49,364,340	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	10,047,905	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	78,440,147	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	21,995,974	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	52,693,780	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	95,400,138	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	11,501,653	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	16,850,505	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	28,475,752	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,254,757	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	216,780	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,476,230	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,504,039	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	127,916	127,916	79,185,511	0.001615	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	1,068,440	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	8,128,505	0.000000	70.00
70.01	07001	ELECTROSHOCK THERAPY	0	0	0	932,628	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	29,205,619	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	42,273,434	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	287,137,280	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	7,352,785	0.000000	74.00
76.00	03330	ENDOSCOPY	0	0	0	16,403,306	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	26,076,720	0.000000	90.00
91.00	09100	EMERGENCY	0	127,916	127,916	100,398,223	0.001274	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	24,408,996	0.000000	92.00
200.00		Total (lines 50 through 199)	0	255,832	255,832	1,284,713,783		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0104 | Component CCN: 26-5842 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/28/2019 12:59 pm

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	0.001615	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	0.001274	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 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 12:59 pm

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)	95,986	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	95,986	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.	68,305	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	19,734	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	27,233	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)	76,660,482	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)	76,660,482	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	179,595,053	28.00
29.00	Private room charges (excluding swing-bed charges)	148,558,208	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	31,036,845	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.426852	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	2,174.92	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,572.76	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	602.16	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	257.03	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	17,556,434	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	59,104,048	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	798.66	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	21,749,908	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)	21,749,908	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 12:59 pm

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	17,477,009	14,961	1,168.17	1,953	2,281,436	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)	39,148,607	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	63,179,951	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)	1,508,514	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	2,359,057	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	3,867,571	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	59,312,380	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)	7,947	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	798.66	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	6,346,951	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 12:59 pm

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	4,689,787	76,660,482	0.061176	6,346,951	388,281	90.00
91.00	Nursing School cost	0	76,660,482	0.000000	6,346,951	0	91.00
92.00	Allied health cost	127,916	76,660,482	0.001669	6,346,951	10,593	92.00
93.00	All other Medical Education	0	76,660,482	0.000000	6,346,951	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 26-0104 Component CCN: 26-S104	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/28/2019 12:59 pm
	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)	6,331	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,331	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.	312	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	6,019	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)	2,803	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)	4,080,611	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)	4,080,611	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	9,274,794	28.00
29.00	Private room charges (excluding swing-bed charges)	459,492	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	8,815,302	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.439968	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	1,472.73	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,464.58	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	8.15	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	3.59	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	1,120	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,079,491	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)	644.54	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,806,646	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)	1,806,646	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1

Component CCN: 26-S104 | Date/Time Prepared: 5/28/2019 12:59 pm

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)	254,054	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,060,700	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)	333,193	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	11,468	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	344,661	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,716,039	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 Component CCN: 26-S104	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/28/2019 12:59 pm
	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	624,664	4,080,611	0.153081	0	0	90.00
91.00	Nursing School cost	0	4,080,611	0.000000	0	0	91.00
92.00	Allied health cost	127,916	4,080,611	0.031347	0	0	92.00
93.00	All other Medical Education	0	4,080,611	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 26-0104 Component CCN: 26-5842	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/28/2019 12:59 pm
	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)	16,980	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	16,980	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)	16,980	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)	3,466	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)	5,513,091	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,513,091	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,513,091	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		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 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1

Component CCN: 26-5842 | Date/Time Prepared: 5/28/2019 12:59 pm

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)	5,513,091	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	324.68	71.00
72.00	Program routine service cost (line 9 x line 71)	1,125,341	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)	1,125,341	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)	1,125,341	83.00
84.00	Program inpatient ancillary services (see instructions)	426,322	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)	1,551,663	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 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/28/2019 12:59 pm
	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 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 12:59 pm

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)	95,986	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	95,986	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.	68,305	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	19,734	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)	15,100	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)	2,281	15.00
16.00	Nursery days (title V or XIX only)	154	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)	76,613,859	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)	76,613,859	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)	23,355,262	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	4,879,392	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	2.713469	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	341.93	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	247.26	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	94.67	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	256.88	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	17,546,188	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	59,067,671	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)	615.38	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	9,292,238	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)	9,292,238	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 12:59 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	3,068,205	2,281	1,345.11	154	207,147	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	17,477,009	14,961	1,168.17	1,724	2,013,925	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)	9,358,305	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	20,871,615	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)	7,947	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	798.18	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	6,343,136	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 12:59 pm

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	4,689,787	76,613,859	0.061213	6,343,136	388,282	90.00
91.00	Nursing School cost	0	76,613,859	0.000000	6,343,136	0	91.00
92.00	Allied health cost	0	76,613,859	0.000000	6,343,136	0	92.00
93.00	All other Medical Education	0	76,613,859	0.000000	6,343,136	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 26-0104 Component CCN: 26-S104	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/28/2019 12:59 pm
	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)	6,331	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,331	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.	312	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	6,019	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)	1,667	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)	2,281	15.00
16.00	Nursery days (title V or XIX only)	154	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)	4,080,611	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)	4,080,611	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)	148,780	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	2,854,319	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.358800	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	476.86	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	474.22	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	2.64	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	3.59	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	1,120	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,079,491	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)	644.37	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,074,165	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)	1,074,165	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-0104 | Component CCN: 26-S104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 12:59 pm

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)	156,026	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,230,191	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
Component CCN: 26-S104

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

Worksheet D-1
Date/Time Prepared:
5/28/2019 12:59 pm

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	624,664	4,080,611	0.153081	0	0	90.00
91.00	Nursing School cost	0	4,080,611	0.000000	0	0	91.00
92.00	Allied health cost	0	4,080,611	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,080,611	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 26-0104 Component CCN: 26-5842	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/28/2019 12:59 pm
	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)	16,980	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	16,980	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)	16,980	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)	12,046	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)	2,281	15.00
16.00	Nursery days (title V or XIX only)	154	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)	5,513,091	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,513,091	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,513,091	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		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 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 12:59 pm

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)	5,513,091	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	324.68	71.00
72.00	Program routine service cost (line 9 x line 71)	3,911,095	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)	3,911,095	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	145,191	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	8.55	76.00
77.00	Program capital-related costs (line 9 x line 76)	102,993	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	3,808,102	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)	3,808,102	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)	102,993	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)	102,993	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 01/01/2018 To 12/31/2018 | Worksheet D-1

Component CCN: 26-5842 | Date/Time Prepared: 5/28/2019 12:59 pm

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 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/28/2019 12:59 pm

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		47,620,417		30.00
31.00	03100	INTENSIVE CARE UNIT		17,163,882		31.00
40.00	04000	SUBPROVIDER - IPF		1,342,962		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.209723	28,466,944	5,970,173	50.00
51.00	05100	RECOVERY ROOM	0.132490	2,606,067	345,278	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.220273	23,996	5,286	52.00
52.01	05201	PERINATAL CLINIC	0.294056	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.055043	4,295,498	236,437	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148713	6,530,346	971,147	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.156870	542,963	85,175	55.00
56.00	05600	RADIOISOTOPE	0.255936	1,761,883	450,929	56.00
57.00	05700	CT SCAN	0.028865	11,361,513	327,950	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.090050	2,366,857	213,135	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.079942	6,725,533	537,653	59.00
60.00	06000	LABORATORY	0.056373	21,569,505	1,215,938	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.451835	1,991,616	899,882	62.00
64.00	06400	INTRAVENOUS THERAPY	0.217851	17,890	3,897	64.00
65.00	06500	RESPIRATORY THERAPY	0.196857	6,786,675	1,336,004	65.00
66.00	06600	PHYSICAL THERAPY	0.493416	2,254,520	1,112,416	66.00
66.01	06601	CLINICAL NUTRITION	7.564489	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.335848	982,512	329,975	67.00
68.00	06800	SPEECH PATHOLOGY	0.329502	932,637	307,306	68.00
69.00	06900	ELECTROCARDIOLOGY	0.077549	9,952,267	771,788	69.00
69.01	06901	CARDIAC REHABILITATION	0.502315	22,770	11,438	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.160644	1,281,060	205,795	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.214110	2,686	575	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.129088	7,366,315	8,317,218	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.661912	10,652,874	7,051,265	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.196570	22,246,202	4,372,936	73.00
74.00	07400	RENAL DIALYSIS	0.327789	3,871,556	1,269,053	74.00
76.00	03330	ENDOSCOPY	0.156952	1,115,040	175,008	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.521351	366	191	90.00
91.00	09100	EMERGENCY	0.175039	11,473,799	2,008,362	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.260025	2,370,531	616,397	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		169,572,421	39,148,607	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)		169,572,421		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 26-0104 | Component CCN: 26-S104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/28/2019 12:59 pm

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		4,424,649		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.209723	5,096	1,069	50.00
51.00	05100	RECOVERY ROOM	0.132490	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.220273	0	0	52.00
52.01	05201	PERINATAL CLINIC	0.294056	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.055043	8,523	469	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148713	16,995	2,527	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.156870	427	67	55.00
56.00	05600	RADIOISOTOPE	0.255936	0	0	56.00
57.00	05700	CT SCAN	0.028865	33,600	970	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.090050	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.079942	0	0	59.00
60.00	06000	LABORATORY	0.056373	565,360	31,871	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.451835	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.217851	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.196857	4,323	851	65.00
66.00	06600	PHYSICAL THERAPY	0.493416	288	142	66.00
66.01	06601	CLINICAL NUTRITION	7.564489	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.335848	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.329502	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.077549	11,038	856	69.00
69.01	06901	CARDIAC REHABILITATION	0.502315	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.160644	2,768	445	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.214110	49,381	10,573	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.129088	730	824	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.661912	724	479	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.196570	678,943	133,460	73.00
74.00	07400	RENAL DIALYSIS	0.327789	4,542	1,489	74.00
76.00	03330	ENDOSCOPY	0.156952	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.521351	0	0	90.00
91.00	09100	EMERGENCY	0.175039	388,268	67,962	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.260025	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,771,006	254,054	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)		1,771,006		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 26-0104 | Component CCN: 26-5842 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/28/2019 12:59 pm

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	0.209723	0	0	50.00
51.00	05100	RECOVERY ROOM	0.132490	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.220273	0	0	52.00
52.01	05201	PERINATAL CLINIC	0.294056	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.055043	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148713	5,162	768	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.156870	0	0	55.00
56.00	05600	RADIOISOTOPE	0.255936	0	0	56.00
57.00	05700	CT SCAN	0.028865	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.090050	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.079942	0	0	59.00
60.00	06000	LABORATORY	0.056373	5,846	330	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.451835	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.217851	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.196857	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.493416	407,589	201,111	66.00
66.01	06601	CLINICAL NUTRITION	7.564489	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.335848	400,077	134,365	67.00
68.00	06800	SPEECH PATHOLOGY	0.329502	175,723	57,901	68.00
69.00	06900	ELECTROCARDIOLOGY	0.077549	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.502315	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.160644	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.214110	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.129088	7,459	8,422	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.661912	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.196570	119,169	23,425	73.00
74.00	07400	RENAL DIALYSIS	0.327789	0	0	74.00
76.00	03330	ENDOSCOPY	0.156952	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.521351	0	0	90.00
91.00	09100	EMERGENCY	0.175039	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.260025	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,121,025	426,322	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)		1,121,025		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/28/2019 12:59 pm

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		29,966,363		30.00
31.00	03100	INTENSIVE CARE UNIT		4,965,442		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY		184,215		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.209636	4,611,364	966,708	50.00
51.00	05100	RECOVERY ROOM	0.132490	353,370	46,818	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.220273	350,181	77,135	52.00
52.01	05201	PERINATAL CLINIC	0.294056	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.053869	862,968	46,487	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148713	1,646,330	244,831	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.156870	78,807	12,362	55.00
56.00	05600	RADIOISOTOPE	0.255936	594,079	152,046	56.00
57.00	05700	CT SCAN	0.028865	3,556,857	102,669	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.090050	699,176	62,961	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.079942	1,246,170	99,621	59.00
60.00	06000	LABORATORY	0.056373	9,564,950	539,205	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.451835	610,278	275,745	62.00
64.00	06400	INTRAVENOUS THERAPY	0.217851	885	193	64.00
65.00	06500	RESPIRATORY THERAPY	0.196434	2,048,773	402,449	65.00
66.00	06600	PHYSICAL THERAPY	0.493416	323,780	159,758	66.00
66.01	06601	CLINICAL NUTRITION	7.564489	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.335848	172,903	58,069	67.00
68.00	06800	SPEECH PATHOLOGY	0.329502	169,341	55,798	68.00
69.00	06900	ELECTROCARDIOLOGY	0.077549	2,498,855	193,784	69.00
69.01	06901	CARDIAC REHABILITATION	0.499214	2,460	1,228	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.160199	419,335	67,177	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.214110	73,865	15,815	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.129088	1,659,266	1,873,457	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.661912	968,732	641,215	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.196570	8,938,139	1,756,970	73.00
74.00	07400	RENAL DIALYSIS	0.327789	636,045	208,489	74.00
76.00	03330	ENDOSCOPY	0.156952	297,760	46,734	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.520900	39,739	20,700	90.00
91.00	09100	EMERGENCY	0.175039	6,251,308	1,094,223	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.260025	521,712	135,658	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		49,197,428	9,358,305	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)		49,197,428		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 26-0104 | Component CCN: 26-S104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/28/2019 12:59 pm

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		2,684,085		40.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.209636	0	0	50.00
51.00	05100	RECOVERY ROOM	0.132490	123	16	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.220273	0	0	52.00
52.01	05201	PERINATAL CLINIC	0.294056	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.053869	5,142	277	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148713	12,430	1,849	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.156870	0	0	55.00
56.00	05600	RADIOISOTOPE	0.255936	0	0	56.00
57.00	05700	CT SCAN	0.028865	24,400	704	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.090050	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.079942	0	0	59.00
60.00	06000	LABORATORY	0.056373	404,262	22,789	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.451835	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.217851	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.196434	2,913	572	65.00
66.00	06600	PHYSICAL THERAPY	0.493416	197	97	66.00
66.01	06601	CLINICAL NUTRITION	7.564489	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.335848	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.329502	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.077549	8,400	651	69.00
69.01	06901	CARDIAC REHABILITATION	0.499214	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.160199	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.214110	14,773	3,163	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.129088	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.661912	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.196570	370,496	72,828	73.00
74.00	07400	RENAL DIALYSIS	0.327789	0	0	74.00
76.00	03330	ENDOSCOPY	0.156952	2,427	381	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.520900	2,230	1,162	90.00
91.00	09100	EMERGENCY	0.175039	294,429	51,537	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.260025	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,142,222	156,026	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)		1,142,222		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 26-0104	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/28/2019 12:59 pm
	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)	43,286,864	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	13,749,858	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)	516,626	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	29,911,156	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	411.23	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 that 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.	9.13	11.00
12.00	Current year allowable FTE (see instructions)	9.13	12.00
13.00	Total allowable FTE count for the prior year.	14.22	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.	14.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	12.45	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	12.45	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.030275	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.032743	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.030275	21.00
22.00	IME payment adjustment (see instructions)	935,801	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	490,752	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)	935,801	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	490,752	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	5.78	30.00
31.00	Percentage of Medicaid patient days (see instructions)	29.01	31.00
32.00	Sum of lines 30 and 31	34.79	32.00
33.00	Allowable disproportionate share percentage (see instructions)	17.92	33.00
34.00	Disproportionate share adjustment (see instructions)	2,555,246	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 26-0104	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/28/2019 12:59 pm
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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	6,766,695,164	8,272,872,447	35.00
35.01	Factor 3 (see instructions)	0.000828138	0.000781362	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	5,603,757	6,464,106	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	4,191,302	1,629,310	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	5,820,612		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)	66,865,007		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)	67,355,759	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	5,020,649	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).	412,301	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	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).	58,484	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	31,720	58.00
59.00	Total (sum of amounts on lines 49 through 58)	72,878,913	59.00
60.00	Primary payer payments	102,886	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	72,776,027	61.00
62.00	Deductibles billed to program beneficiaries	5,544,724	62.00
63.00	Coinsurance billed to program beneficiaries	273,970	63.00
64.00	Allowable bad debts (see instructions)	2,317,807	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	1,506,575	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,586,016	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	68,463,908	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)	0	70.93
70.94	HRR adjustment amount (see instructions)	-269,088	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 26-0104	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/28/2019 12:59 pm
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		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)		545,914	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		67,648,906	71.00
71.01	Sequestration adjustment (see instructions)		1,352,978	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		65,853,634	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)		442,294	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		2,296,452	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (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)	0.9948	0.9968	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 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/28/2019 12:59 pm

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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	
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	43,286,864	0	43,286,864		43,286,864	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	13,749,858	0		13,749,858	13,749,858	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	516,626	0	387,512	129,114	516,626	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	29,911,156	0	29,911,156	0	29,911,156	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.030275	0.030275	0.030275	0.030275		5.00
6.00	IME payment adjustment (see instructions)	22.00	935,801	0	710,207	225,594	935,801	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	490,752	0	490,752	0	490,752	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	935,801	0	710,207	225,594	935,801	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	490,752	0	490,752	0	490,752	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1792	0.1792	0.1792	0.1792		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	2,555,246	0	1,939,252	615,994	2,555,246	11.00
11.01	Uncompensated care payments	36.00	5,820,612	0	4,191,302	1,629,310	5,820,612	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	66,865,007	0	50,515,137	16,349,870	66,865,007	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	67,355,759	0	51,005,889	16,349,870	67,355,759	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	5,020,649	0	3,810,572	1,210,077	5,020,649	16.00
17.00	Special add-on payments for new technologies	54.00	0	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 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/28/2019 12:59 pm

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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	54,816,461	17,559,947	72,376,408	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	4,609,096	0	3,498,147	1,110,949	4,609,096	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	18,858	0	14,383	4,475	18,858	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	0.0123	0.0123	0.0123	0.0123		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	56,692	0	43,027	13,665	56,692	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0729	0.0729	0.0729	0.0729		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	336,003	0	255,015	80,988	336,003	25.00
26.00	Total prospective capital payments (see instructions)	12.00	5,020,649	0	3,810,572	1,210,077	5,020,649	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 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/28/2019 12:59 pm

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		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	43,286,864	43,286,864		43,286,864	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	13,749,858		13,749,858	13,749,858	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	516,626	387,512	129,114	516,626	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	29,911,156	29,911,156	0	29,911,156	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.030275	0.030275	0.030275		5.00
6.00	IME payment adjustment (see instructions)	22.00	935,801	710,207	225,594	935,801	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	490,752	490,752	0	490,752	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	935,801	710,207	225,594	935,801	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	490,752	490,752	0	490,752	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1792	0.1792	0.1792		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	2,555,246	1,939,252	615,994	2,555,246	11.00
11.01	Uncompensated care payments	36.00	5,820,612	4,191,302	1,629,310	5,820,612	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	66,865,007	50,515,137	16,349,870	66,865,007	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	67,355,759	51,005,889	16,349,870	67,355,759	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	5,020,649	3,810,572	1,210,077	5,020,649	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	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			54,816,461	17,559,947	72,376,408	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/28/2019 12:59 pm

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		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	4,609,096	3,498,147	1,110,949	4,609,096	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	18,858	14,383	4,475	18,858	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	0.0123	0.0123	0.0123		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	56,692	43,027	13,665	56,692	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0729	0.0729	0.0729		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	336,003	255,015	80,988	336,003	25.00
26.00	Total prospective capital payments (see instructions)	12.00	5,020,649	3,810,572	1,210,077	5,020,649	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	0	0	0	0	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	-269,088	-225,089	-43,999	-269,088	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		545,914	0	545,914	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 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/28/2019 12:59 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	76,337	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	43,239,404	2.00
3.00	OPPS payments	40,367,181	3.00
4.00	Outlier payment (see instructions)	61,928	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	19,501	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	76,337	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	386,817	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)	386,817	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)	386,817	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	310,480	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)	76,337	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)	40,448,610	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	7,861,958	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)	32,662,989	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	262,578	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)	32,925,567	30.00
31.00	Primary payer payments	30,527	31.00
32.00	Subtotal (line 30 minus line 31)	32,895,040	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)	899,095	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	584,412	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	410,260	36.00
37.00	Subtotal (see instructions)	33,479,452	37.00
38.00	MSP-LCC reconciliation amount from PS&R	1,988	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)	6,086	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	33,477,464	40.00
40.01	Sequestration adjustment (see instructions)	669,549	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	32,708,613	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	99,302	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 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/28/2019 12:59 pm
	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)	38,877	2.00
3.00	OPPS payments	48,146	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)	48,146	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	9,869	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)	38,277	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)	38,277	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	38,277	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)	38,277	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	38,277	40.00
40.01	Sequestration adjustment (see instructions)	766	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	37,511	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/28/2019 12:59 pm

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		63,916,816		31,954,295	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		1,832,618		726,818	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	07/09/2018	104,200	07/09/2019	27,500	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)		104,200		27,500	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)		65,853,634		32,708,613	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		442,294		99,302	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		66,295,928		32,807,915	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 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/28/2019 12:59 pm

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		1,838,466		37,511	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		93,119		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)		1,931,585		37,511	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		10,293		0	6.02
7.00	Total Medicare program liability (see instructions)		1,921,292		37,511	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 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/28/2019 12:59 pm

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		1,635,743		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)		1,635,743		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)		1,635,743		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 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/28/2019 12:59 pm
	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 01/01/2018 To 12/31/2018	Worksheet E-3 Part II Date/Time Prepared: 5/28/2019 12:59 pm
	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)	2,261,293	1.00
2.00	Net IPF PPS Outlier Payments	10,920	2.00
3.00	Net IPF PPS ECT Payments	11,628	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)	17.345205	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)	2,283,841	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)	2,283,841	16.00
17.00	Primary payer payments	8,166	17.00
18.00	Subtotal (line 16 less line 17).	2,275,675	18.00
19.00	Deductibles	322,892	19.00
20.00	Subtotal (line 18 minus line 19)	1,952,783	20.00
21.00	Coinsurance	76,715	21.00
22.00	Subtotal (line 20 minus line 21)	1,876,068	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	42,000	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	27,300	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	10,320	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,903,368	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)	57,134	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)	1,960,502	31.00
31.01	Sequestration adjustment (see instructions)	39,210	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	1,931,585	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)	-10,293	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	10,920	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 01/01/2018 To 12/31/2018	Worksheet E-3 Part VI Date/Time Prepared: 5/28/2019 12:59 pm
	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)	1,803,461	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)	1,803,461	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	134,335	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)	1,669,126	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	1,669,126	15.00
15.01	Sequestration adjustment (see instructions)	33,383	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
16.00	Interim payments	1,635,743	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 01/01/2018 To 12/31/2018 | Worksheet E-4 | Date/Time Prepared: 5/28/2019 12:59 pm

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		9.13		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		9.13		10.01
11.00	Total weighted FTE count	0.00	9.13		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	14.22		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	14.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	12.45		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	12.45		17.00
18.00	Per resident amount	119,810.42	119,810.42		18.00
19.00	Approved amount for resident costs	0	1,491,640	1,491,640	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 locality adjustment national average per resident amount (see instructions)			106,670.18	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)			1,491,640	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions)	31,989	20,575		26.00
27.00	Total Inpatient Days (see instructions)	109,753	109,753		27.00
28.00	Ratio of inpatient days to total inpatient days	0.291464	0.187466		28.00
29.00	Program direct GME amount	434,759	279,632		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		39,512		30.00
31.00	Net Program direct GME amount			674,879	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 26-0104	Period: From 01/01/2018 To 12/31/2018	Worksheet E-4 Date/Time Prepared: 5/28/2019 12:59 pm
	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)	7,352,785	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)	68,169,453	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)	111,052	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	68,058,401	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	43,374,119	42.00
43.00	Primary payer payments (see instructions)	30,527	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	43,343,592	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	111,401,993	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.610926	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.389074	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	674,879	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	412,301	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	262,578	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 01/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 5/28/2019 12:59 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	85,100,344	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	62,617,681	0	0	0	4.00
5.00	Other receivable	6,672,001	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	7,562,791	0	0	0	7.00
8.00	Prepaid expenses	1,050,550	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)	163,003,367	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	-2,225,580	0	0	0	14.00
15.00	Buildings	113,330,498	0	0	0	15.00
16.00	Accumulated depreciation	-49,456,554	0	0	0	16.00
17.00	Leasehold improvements	3,015,702	0	0	0	17.00
18.00	Accumulated depreciation	-1,727,490	0	0	0	18.00
19.00	Fixed equipment	3,739,894	0	0	0	19.00
20.00	Accumulated depreciation	-1,958,099	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	85,975,931	0	0	0	23.00
24.00	Accumulated depreciation	-58,974,185	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)	104,200,868	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	2,860,302	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	13,235,278	2,242,382	138,956	0	34.00
35.00	Total other assets (sum of lines 31-34)	16,095,580	2,242,382	138,956	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	283,299,815	2,242,382	138,956	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	21,491,860	0	0	0	37.00
38.00	Salaries, wages, and fees payable	9,014,112	0	0	0	38.00
39.00	Payroll taxes payable	196,439	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,557,606	0	0	0	40.00
41.00	Deferred income	-889,571	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	16,522,325	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	47,892,771	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	20,686,525	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	20,686,525	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	68,579,296	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	214,720,519				52.00
53.00	Specific purpose fund		2,242,382			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)	214,720,519	2,242,382	138,956	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	283,299,815	2,242,382	138,956	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 5/28/2019 12:59 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		173,889,930		1,831,606		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		71,626,454				2.00
3.00	Total (sum of line 1 and line 2)		245,516,384		1,831,606		3.00
4.00	ADDITIONA (CREDIT ADJUSTMENTS)	0		410,776		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)		0		410,776		10.00
11.00	Subtotal (line 3 plus line 10)		245,516,384		2,242,382		11.00
12.00	DEDUCTIONS (CREDIT ADJUSTMENTS)	275,718		0		0	12.00
13.00	CORPORATE OFFICE	30,520,147		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		30,795,865		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		214,720,519		2,242,382		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	ADDITIONA (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	DEDUCTIONS (CREDIT ADJUSTMENTS)		0			12.00
13.00	CORPORATE OFFICE		0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	138,956		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 26-0104 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/28/2019 12:59 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	174,108,106		174,108,106	1.00
2.00	SUBPROVIDER - IPF	11,021,876		11,021,876	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	4,303,671		4,303,671	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)	189,433,653		189,433,653	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	45,914,502		45,914,502	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)	45,914,502		45,914,502	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	235,348,155		235,348,155	17.00
18.00	Ancillary services	484,991,090	692,331,076	1,177,322,166	18.00
19.00	Outpatient services	48,479,801	104,299,702	152,779,503	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 PROFESSIONAL FEES	3,977,894	12,925,009	16,902,903	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	772,796,940	809,555,787	1,582,352,727	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		418,109,116		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)		418,109,116		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 26-0104	Period: From 01/01/2018 To 12/31/2018	Worksheet G-3 Date/Time Prepared: 5/28/2019 12:59 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,582,352,727	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,134,681,073	2.00
3.00	Net patient revenues (line 1 minus line 2)	447,671,654	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	418,109,116	4.00
5.00	Net income from service to patients (line 3 minus line 4)	29,562,538	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	691,622	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	12,729	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	1,753,809	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	0	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	446,908	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	39,174,554	24.00
25.00	Total other income (sum of lines 6-24)	42,079,622	25.00
26.00	Total (line 5 plus line 25)	71,642,160	26.00
27.00	OTHER EXPENSES	15,706	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	15,706	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	71,626,454	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 26-0104	Period: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Prepared: 5/28/2019 12:59 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	4,609,096	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	18,858	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)	287.49	3.00
4.00	Number of interns & residents (see instructions)	12.45	4.00
5.00	Indirect medical education percentage (see instructions)	1.23	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)	56,692	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	5.78	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	29.01	8.00
9.00	Sum of lines 7 and 8	34.79	9.00
10.00	Allowable disproportionate share percentage (see instructions)	7.29	10.00
11.00	Disproportionate share adjustment (see instructions)	336,003	11.00
12.00	Total prospective capital payments (see instructions)	5,020,649	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