

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 140033	Period: From 12/01/2014 To 11/30/2015	Worksheet S Parts I-III Date/Time Prepared: 4/28/2016 11:10 am
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<b>PART I - COST REPORT STATUS</b>			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 4/28/2016	Time: 11:10 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY 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 VISTA MEDICAL CENTER WEST ( 140033 ) for the cost reporting period beginning 12/01/2014 and ending 11/30/2015 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.

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

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Date

Cost Center Description	Title XVIII			HIT	Title XIX	
	Title V	Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	-8,649	29,515	-152,684		0 1.00
2.00 Subprovider - IPF	0	-22,001	-1			0 2.00
3.00 Subprovider - IRF	0	22,102	1,525			0 3.00
5.00 Swing bed - SNF	0	0	0			0 5.00
6.00 Swing bed - NF	0					0 6.00
10.00 RURAL HEALTH CLINIC I	0		0			0 10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0			0 11.00
200.00 Total	0	-8,548	31,039	-152,684		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: 140033	Period: From 12/01/2014 To 11/30/2015	Worksheet S-2 Part I Date/Time Prepared: 4/28/2016 11:04 am				
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1324 NORTH SHERIDAN ROAD			PO Box:						1.00	
2.00	City: WAUKEGAN			State: IL		Zip Code: 60085-		County: LAKE		2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		VI STA MEDICAL CENTER WEST	140033	29404	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF		VI STA MEDICAL CENTER MENTAL HEALTH	14S033	29404	4	01/01/1990	N	P	N	4.00
5.00	Subprovider - IRF		VI STA MEDICAL CENTER REHAB	14T033	29404	5	09/01/1989	N	P	N	5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
17.10	Hospital-Based (CORF) I										17.10
18.00	Renal Dialysis										18.00
19.00	Other										19.00
						From:	To:				
						1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)					12/01/2014	11/30/2015		20.00		
21.00	Type of Control (see instructions)					4		21.00			
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(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)					N	N		22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3		N		23.00	
			In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days			
			1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.		2,178	0	0	0	0	0		24.00	

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		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	345	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	
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)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00	
						V	XVII	XIX	
						1.00	2.00	3.00	
<b>Prospective Payment System (PPS)-Capital</b>									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
<b>Teaching Hospitals</b>									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					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
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)					N			60.00
		Y/N	IME	Direct GME	IME	Direct GME			
		1.00	2.00	3.00	4.00	5.00			
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)					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)		0.00	0.00				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)		0.00	0.00				61.02	

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	Y/N	IME	Direct GME	IME	Direct GME		
	1.00	2.00	3.00	4.00	5.00		
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)	0.00	0.00				61.03
61.04	Enter the number of unweighted primary care/surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).	0.00	0.00				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)	0.00	0.00				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)	0.00	0.00				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 and enter in column 4, 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 and enter in column 4, 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 64-67. (see instructions)				N		63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
					1.00	2.00	
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	
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
<b>Inpatient Psychiatric Facility PPS</b>							
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 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	0	71.00
<b>Inpatient Rehabilitation Facility PPS</b>							
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.				Y		75.00
76.00	If line 75 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

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				1.00	
<b>Long Term Care Hospital PPS</b>					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00
<b>TEFRA Providers</b>					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			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 a "subclause (11)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.			N	87.00
		V	XIX		
		1.00	2.00		
<b>Title V and XIX Services</b>					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	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	
<b>Rural Providers</b>					
105.00	Does this hospital qualify as a critical access hospital (CAH)?			N	105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			N	106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.			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 1.00	Occupational 2.00	Speech 3.00	Respiratory 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
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N	110.00
		1.00	2.00	3.00	
<b>Miscellaneous Cost Reporting Information</b>					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			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 1.00	Losses 2.00	Insurance 3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	233,260	0	118.01

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		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02		
119.00	DO NOT USE THIS LINE			119.00		
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00		
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00		
<b>Transplant Center Information</b>						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00		
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00		
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00		
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00		
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00		
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00		
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00		
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00		
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00		
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00		
<b>All Providers</b>						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	449008	140.00		
		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: COMMUNITY HEALTH SYSTEMS	Contractor's Name: WPS	Contractor's Number: 10101	141.00		
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00		
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00		
			1.00			
144.00	Are provider based physicians' costs included in Worksheet A?		Y	144.00		
			1.00	2.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N		145.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00		
			1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N	147.00		
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N	148.00		
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N	149.00		
		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)						
155.00	Hospital	N	N	N	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
161.10	CORF		N	N	N	161.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140033		Period: From 12/01/2014 To 11/30/2015		Worksheet S-2 Part I Date/Time Prepared: 4/28/2016 11:04 am		
							1.00	
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	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)							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)						0.75	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)				01/22/2014	04/21/2014	170.00	
							1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)						N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140033	Period: From 12/01/2014 To 11/30/2015	Worksheet S-2 Part II Date/Time Prepared: 4/28/2016 11:04 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
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	
		1.00	2.00	3.00	
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	03/14/2016	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140033	Period: From 12/01/2014 To 11/30/2015	Worksheet S-2 Part II Date/Time Prepared: 4/28/2016 11:04 am		
	Description	Part A		Part B		
		Y/N	Date	Y/N		
	0	1.00	2.00	3.00		
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00	
				1.00		
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>						
<b>Capital Related Cost</b>						
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00	
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00	
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00	
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00	
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00	
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00	
<b>Interest Expense</b>						
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00	
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00	
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00	
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00	
<b>Purchased Services</b>						
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00	
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00	
<b>Provider-Based Physicians</b>						
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			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			
<b>Home Office Costs</b>						
36.00	Were home office costs claimed on the cost report?			Y	36.00	
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00	
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			Y	12/31/2013	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			
<b>Cost Report Preparer Contact Information</b>						
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JENNIFER	RAY		41.00	
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS			42.00	
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-465-7390	JENNIFER_RAY2@CHS.NET		43.00	

		Part B		
		Date		
		4.00		
<b>PS&amp;R Data</b>				
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)	03/14/2016		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00
			3.00	
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REVENUE MANAGEMENT		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: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet S-3  
Part I  
Date/Time Prepared:  
4/28/2016 11:04 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi si ts / Tri ps	
					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	16	5,840	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)		16	5,840	0.00	0	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)		16	5,840	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	26	9,490		0	16.00
17.00 SUBPROVIDER - IRF	41.00	25	9,125		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						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
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		67				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet S-3  
Part I  
Date/Time Prepared:  
4/28/2016 11:04 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	119	2,178	3,302			1.00
2.00 HMO and other (see instructions)	15	0				2.00
3.00 HMO IPF Subprovider	326	0				3.00
4.00 HMO IRF Subprovider	181	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)	119	2,178	3,302			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)	119	2,178	3,302	0.00	74.71	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	1,034	2,639	5,606	0.00	21.36	16.00
17.00 SUBPROVIDER - IRF	1,963	466	3,497	0.00	15.85	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00 RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	111.92	27.00
28.00 Observation Bed Days		0	0			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet S-3  
Part I  
Date/Time Prepared:  
4/28/2016 11:04 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	15	305	462	1.00
2.00 HMO and other (see instructions)				0	0		2.00
3.00 HMO IPF Subprovider					0		3.00
4.00 HMO IRF Subprovider					0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0	15	305	462		14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF	0.00	0	138	496	998		16.00
17.00 SUBPROVIDER - IRF	0.00	0	143	32	253		17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							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
25.10 CMHC - CORF	0.00						25.10
26.00 RURAL HEALTH CLINIC	0.00						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00						26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days							33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 140033	Period: From 12/01/2014 To 11/30/2015	Worksheet S-3 Part II Date/Time Prepared: 4/28/2016 11:04 am
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	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal ari es (from Worksheet A-6)	Adjusted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	7,166,050	0	7,166,050	232,792.00	30.78
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		2,420,939	0	2,420,939	77,392.00	31.28
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract labor: Direct Patient Care		1,900	0	1,900	32.00	59.38
12.00	Contract labor: Top level management and other management and administrative services		38,401	0	38,401	1,822.00	21.08
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office salaries & wage-related costs		377,104	0	377,104	7,181.00	52.51
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) (see instructions)		972,883	0	972,883		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		500,591	0	500,591		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26.00	Employee Benefits Department	4.00	0	0	0	0.00	0.00
27.00	Administrative & General	5.00	128,984	0	128,984	8,209.00	15.71
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	272,381	0	272,381	10,813.00	25.19
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	0	0	0	0.00	0.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	30,936	0	30,936	650.00	47.59
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet S-3  
Part II  
Date/Time Prepared:  
4/28/2016 11:04 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adjusted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet S-3  
Part III  
Date/Time Prepared:  
4/28/2016 11:04 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal ari es (from Worksheet A-6)	Adjusted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	7,166,050	0	7,166,050	232,792.00	30.78	1.00
2.00	Excluded area salaries (see instructions)	2,420,939	0	2,420,939	77,392.00	31.28	2.00
3.00	Subtotal salaries (line 1 minus line 2)	4,745,111	0	4,745,111	155,400.00	30.53	3.00
4.00	Subtotal other wages & related costs (see inst.)	417,405	0	417,405	9,035.00	46.20	4.00
5.00	Subtotal wage-related costs (see inst.)	972,883	0	972,883	0.00	20.50	5.00
6.00	Total (sum of lines 3 thru 5)	6,135,399	0	6,135,399	164,435.00	37.31	6.00
7.00	Total overhead cost (see instructions)	432,301	0	432,301	19,672.00	21.98	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140033	Period: From 12/01/2014 To 11/30/2015	Worksheet S-3 Part IV Date/Time Prepared: 4/28/2016 11:04 am
				Amount Reported
				1.00
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions			121,276 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0 4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
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
<b>HEALTH AND INSURANCE COST</b>				
8.00	Health Insurance (Purchased or Self Funded)			586,084 8.00
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			6,056 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			4,908 11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			491 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			21,317 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			159,887 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
<b>TAXES</b>				
17.00	FICA-Employers Portion Only			426,916 17.00
18.00	Medicare Taxes - Employers Portion Only			99,843 18.00
19.00	Unemployment Insurance			0 19.00
20.00	State or Federal Unemployment Taxes			46,678 20.00
<b>OTHER</b>				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			0 21.00
22.00	Day Care Cost and Allowances			0 22.00
23.00	Tuition Reimbursement			0 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			1,473,456 24.00
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			1,082 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet S-3  
Part V  
Date/Time Prepared:  
4/28/2016 11:04 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
<b>PART V - Contract Labor and Benefit Cost</b>				
<b>Hospital and Hospital-Based Component Identification:</b>				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	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			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	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 140033	Period: From 12/01/2014 To 11/30/2015	Worksheet S-10 Date/Time Prepared: 4/28/2016 11:04 am
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			1.00		
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.136892	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		3,276,730	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N	4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		1,578,015	5.00	
6.00	Medicaid charges		51,643,996	6.00	
7.00	Medicaid cost (line 1 times line 6)		7,069,650	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)		2,214,905	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		2,858	9.00	
10.00	Stand-alone SCHIP charges		65,555	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		8,974	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		6,116	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	
Uncompensated care (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, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		2,221,021	19.00	
			1.00		
			2.00		
			3.00		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	627,241	6,667	633,908	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	85,864	913	86,777	21.00
22.00	Partial payment by patients approved for charity care	120	0	120	22.00
23.00	Cost of charity care (line 21 minus line 22)	85,744	913	86,657	23.00
			1.00		
24.00	Does the amount in 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?			24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			2,947,959	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			115,523	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			2,832,436	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			387,738	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			474,395	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			2,695,416	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet A  
Date/Time Prepared:  
4/28/2016 11:04 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		643,647	643,647	36,194	679,841	1.00
2.00	00200		148,167	148,167	58,444	206,611	2.00
4.00	00400		50	50	901,101	901,151	4.00
5.00	00500	128,984	6,789,626	6,918,610	-932,402	5,986,208	5.00
7.00	00700	272,381	1,452,368	1,724,749	0	1,724,749	7.00
8.00	00800	0	144,356	144,356	0	144,356	8.00
9.00	00900	0	1,451	1,451	0	1,451	9.00
10.00	01000	0	314,535	314,535	0	314,535	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	30,936	8,631	39,567	0	39,567	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	261,134	261,134	-260,196	938	15.00
16.00	01600	0	692	692	0	692	16.00
17.00	01700	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	882,216	82,396	964,612	-145	964,467	30.00
40.00	04000	1,247,671	193,500	1,441,171	-348	1,440,823	40.00
41.00	04100	1,173,268	235,287	1,408,555	-313	1,408,242	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
54.00	05400	41,229	26,516	67,745	296,486	364,231	54.00
54.01	05401	13,544	11,417	24,961	-24,961	0	54.01
57.00	05700	173,357	98,168	271,525	-271,525	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	714,128	467,961	1,182,089	-19,012	1,163,077	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	0	21,567	21,567	-5,337	16,230	65.00
66.00	06600	447,354	46,708	494,062	300,073	794,135	66.00
67.00	06700	193,299	19,659	212,958	-212,958	0	67.00
68.00	06800	80,350	6,765	87,115	-87,115	0	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	227,373	227,373	73.00
76.00	03020	798,839	183,155	981,994	0	981,994	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	968,494	243,300	1,211,794	0	1,211,794	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
118.00		7,166,050	11,401,056	18,567,106	5,359	18,572,465	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.02	19001	0	0	0	0	0	190.02
192.00	19200	0	28,589	28,589	-13,449	15,140	192.00
192.01	19201	0	0	0	8,040	8,040	192.01
194.00	07950	0	0	0	50	50	194.00
200.00		7,166,050	11,429,645	18,595,695	0	18,595,695	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet A  
Date/Time Prepared:  
4/28/2016 11:04 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	248,340	928,181	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	40,573	247,184	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	901,151	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-5,205,999	780,209	5.00
7.00	00700	OPERATION OF PLANT	290,784	2,015,533	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	144,356	8.00
9.00	00900	HOUSEKEEPING	757,687	759,138	9.00
10.00	01000	DIETARY	0	314,535	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	39,567	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	0	938	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-459	233	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	0	964,467	30.00
40.00	04000	SUBPROVIDER - I PF	587	1,441,410	40.00
41.00	04100	SUBPROVIDER - I RF	0	1,408,242	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	364,231	54.00
54.01	05401	ULTRA SOUND	0	0	54.01
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-67,685	1,095,392	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	16,230	65.00
66.00	06600	PHYSICAL THERAPY	0	794,135	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
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	227,373	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0	981,994	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	23,299	1,235,093	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
99.10	09910	CORF	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,912,873	14,659,592	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.02	19001	WORKPOWER/CORP HEALTH	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	15,140	192.00
192.01	19201	VISTA MEDICAL CENTER EAST	0	8,040	192.01
194.00	07950	MARKETING	0	50	194.00
200.00		TOTAL (SUM OF LINES 118-199)	-3,912,873	14,682,822	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - EMPLOYEE BENEFITS</b>					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	901,101	1.00
	O		0	901,101	
<b>C - RENT AND LEASE EXPENSE</b>					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	58,444	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
	O		0	58,444	
<b>D - OTHER CAPITAL COSTS</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	36,194	1.00
	O		0	36,194	
<b>E - MARKETING DEPARTMENT</b>					
1.00	MARKETING	194.00	0	50	1.00
	O		0	50	
<b>F - DRUGS AND IV SOLUTIONS</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	227,373	1.00
	O		0	227,373	
<b>G - PT, OT, SP COSTS</b>					
1.00	PHYSICAL THERAPY	66.00	273,649	26,424	1.00
2.00		0.00	0	0	2.00
	O		273,649	26,424	
<b>H - OTHER RADIOLOGY COSTS</b>					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	186,901	109,585	1.00
2.00		0.00	0	0	2.00
	O		186,901	109,585	
<b>I - MOB COSTS</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,409	1.00
2.00	VISTA MEDICAL CENTER EAST	192.01	0	8,040	2.00
	O		0	13,449	
500.00	Grand Total: Increases		460,550	1,372,620	500.00

RECLASSIFICATIONS

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet A-6

Date/Time Prepared:  
4/28/2016 11:04 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - EMPLOYEE BENEFITS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	901,101	0		1.00
	O		0	901,101			
<b>C - RENT AND LEASE EXPENSE</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	466	10		1.00
2.00	PHARMACY	15.00	0	32,823	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	145	0		3.00
4.00	SUBPROVIDER - IPF	40.00	0	348	0		4.00
5.00	SUBPROVIDER - IRF	41.00	0	313	0		5.00
6.00	LABORATORY	60.00	0	19,012	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	5,337	0		7.00
	O		0	58,444			
<b>D - OTHER CAPITAL COSTS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	36,194	13		1.00
	O		0	36,194			
<b>E - MARKETING DEPARTMENT</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	50	0		1.00
	O		0	50			
<b>F - DRUGS AND IV SOLUTIONS</b>							
1.00	PHARMACY	15.00	0	227,373	0		1.00
	O		0	227,373			
<b>G - PT, OT, SP COSTS</b>							
1.00	OCCUPATIONAL THERAPY	67.00	193,299	19,659	0		1.00
2.00	SPEECH PATHOLOGY	68.00	80,350	6,765	0		2.00
	O		273,649	26,424			
<b>H - OTHER RADIOLOGY COSTS</b>							
1.00	ULTRA SOUND	54.01	13,544	11,417	0		1.00
2.00	CT SCAN	57.00	173,357	98,168	0		2.00
	O		186,901	109,585			
<b>I - MOB COSTS</b>							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	13,449	0		1.00
2.00		0.00	0	0	0		2.00
	O		0	13,449			
500.00	Grand Total: Decreases		460,550	1,372,620			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet A-7  
Part I  
Date/Time Prepared:  
4/28/2016 11:04 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	1,970,715	0	0	0	1.00
2.00	Land Improvements	534,566	0	0	0	2.00
3.00	Buildings and Fixtures	27,326,158	0	0	0	3.00
4.00	Building Improvements	3,131,021	0	0	0	4.00
5.00	Fixed Equipment	5,712,478	0	0	0	5.00
6.00	Movable Equipment	23,670,014	409	0	409	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	62,344,952	409	0	409	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	62,344,952	409	0	409	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	1,970,715	0			1.00
2.00	Land Improvements	534,566	0			2.00
3.00	Buildings and Fixtures	27,326,158	0			3.00
4.00	Building Improvements	3,131,021	0			4.00
5.00	Fixed Equipment	5,712,478	0			5.00
6.00	Movable Equipment	23,670,423	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	62,345,361	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	62,345,361	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet A-7  
Part II  
Date/Time Prepared:  
4/28/2016 11:04 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	643,647	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	148,167	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	791,814	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	643,647				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	148,167				2.00
3.00	Total (sum of lines 1-2)	0	791,814				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet A-7  
Part III  
Date/Time Prepared:  
4/28/2016 11:04 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	32,962,460	0	32,962,460	0.528708	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	29,382,901	0	29,382,901	0.471292	0	2.00
3.00	Total (sum of lines 1-2)	62,345,361	0	62,345,361	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	220,157	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	188,740	58,444	2.00
3.00	Total (sum of lines 1-2)	0	0	0	408,897	58,444	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	671,830	0	36,194	0	928,181	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	247,184	2.00
3.00	Total (sum of lines 1-2)	671,830	0	36,194	0	1,175,365	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet A-8

Date/Time Prepared:  
4/28/2016 11:04 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			3.00	4.00			
		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	-711,764				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	1,234,366				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	B	-459		MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)	B	-171,740		ADMINISTRATIVE & GENERAL	5.00	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	A	-407,069		CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	A	17,797		CAP REL COSTS-MVBLE EQUIP	2.00	9	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 RENTAL INCOME	B	-27,238		CAP REL COSTS-BLDG & FIXT	1.00	9	33.00
33.01 LOBBYING EXPENSE	A	-1,747		ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet A-8

Date/Time Prepared:  
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
35.00 BAD DEBTS	A	-2,549,946	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00 PHONE & TV DEPRECIATION	A	-584	CAP REL COSTS-MVBLE EQUIP	2.00	9	36.00
36.01 PHONE & TV	A	-14,098	ADMINISTRATIVE & GENERAL	5.00	0	36.01
37.00 STATE OPERATING TAX	A	-2,352,021	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00 MISC REVENUE	B	-140	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00 ALLOCATED SECURITY / PLANT OPS	A	290,784	OPERATION OF PLANT	7.00	0	39.00
40.00 ALLOCATED HOUSEKEEPING	A	757,687	HOUSEKEEPING	9.00	0	40.00
44.00 ALLOCATED EKG	A	23,299	EMERGENCY	91.00	0	44.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,912,873				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: 140033

Period: From 12/01/2014 To 11/30/2015

Worksheet A-8-1

Date/Time Prepared: 4/28/2016 11:04 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST EXPENSE	671,830	0
2.00	5.00	ADMINISTRATIVE & GENERAL	PASI OPERATING COSTS	116,803	142,998
3.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL	7,463	0
4.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	3,354	0
4.01	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	22,270	0
4.02	5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL HOME OFFICE COST	321,293	0
4.03	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE COST	233,260	0
4.04	5.00	ADMINISTRATIVE & GENERAL	ALLOCATION FROM VISTA EAST	1	0
4.05	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL	1,090	0
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,377,364	142,998

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

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

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

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

6.00	B	CHS	100.00	COMMUNITY HEALTH SYSTEMS	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet A-8-1

Date/Time Prepared:  
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	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	671,830	11		1.00
2.00	-26,195	0		2.00
3.00	7,463	9		3.00
4.00	3,354	9		4.00
4.01	22,270	9		4.01
4.02	321,293	0		4.02
4.03	233,260	0		4.03
4.04	1	0		4.04
4.05	1,090	9		4.05
5.00	1,234,366			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	Type of Business		
		6.00	
<b>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>			

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet A-8-2

Date/Time Prepared:  
4/28/2016 11:04 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	644,666	644,666	0	0	0	1.00
2.00	40.00	SUBPROVIDER - IPF	-587	-587	0	0	0	2.00
3.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	67,685	67,685	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			711,764	711,764	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	2.00
3.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	644,666		1.00
2.00	40.00	SUBPROVIDER - IPF	0	0	0	-587		2.00
3.00	41.00	SUBPROVIDER - IRF	0	0	0	0		3.00
4.00	60.00	LABORATORY	0	0	0	67,685		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	711,764		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet B  
Part I  
Date/Time Prepared:  
4/28/2016 11:04 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	928,181	928,181			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	247,184		247,184		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	901,151	0	0	901,151	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	780,209	33,920	9,033	16,220	5.00
7.00 00700	OPERATION OF PLANT	2,015,533	541,727	144,267	34,253	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	144,356	11,775	3,136	0	8.00
9.00 00900	HOUSEKEEPING	759,138	26,510	7,060	0	9.00
10.00 01000	DIETARY	314,535	7,051	1,878	0	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	39,567	0	0	3,890	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	938	14,526	3,868	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	233	6,204	1,652	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	964,467	33,311	8,871	110,941	30.00
40.00 04000	SUBPROVIDER - I PF	1,441,410	48,676	12,963	156,898	40.00
41.00 04100	SUBPROVIDER - IRF	1,408,242	45,029	11,992	147,542	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	0	0	0	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	364,231	0	0	28,688	54.00
54.01 05401	ULTRA SOUND	0	0	0	0	54.01
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MRI	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	1,095,392	30,383	8,091	89,804	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	16,230	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	794,135	21,028	5,600	90,668	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	227,373	0	0	0	73.00
76.00 03020	MENTAL HEALTH ANCILLARY	981,994	19,826	5,280	100,456	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	1,235,093	61,269	16,317	121,791	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 09910	CORF	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	14,659,592	901,235	240,008	901,151	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.02 19001	WORKPOWER/CORP HEALTH	0	0	0	0	190.02
192.00 19200	PHYSICIANS' PRIVATE OFFICES	15,140	0	0	0	192.00
192.01 19201	VI STA MEDICAL CENTER EAST	8,040	26,946	7,176	0	192.01
194.00 07950	MARKETING	50	0	0	0	194.00
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	14,682,822	928,181	247,184	901,151	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet B  
Part I  
Date/Time Prepared:  
4/28/2016 11:04 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	839,382				5.00	
7.00	00700	OPERATION OF PLANT	165,880	2,901,660			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	9,657	96,916	265,840		8.00	
9.00	00900	HOUSEKEEPING	48,065	218,201	0	1,058,974	9.00	
10.00	01000	DIETARY	19,613	58,037	0	23,761	424,875	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,635	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,172	119,559	0	48,950	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	490	51,064	0	20,907	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	67,764	274,179	42,307	112,254	0	30.00
40.00	04000	SUBPROVIDER - IPF	100,649	400,645	61,822	164,031	134,893	40.00
41.00	04100	SUBPROVIDER - IRF	97,791	370,630	57,189	151,742	256,075	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,824	0	0	0	0	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	74,196	250,075	0	102,385	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	984	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	55,264	173,080	26,706	70,862	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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	13,787	0	0	0	0	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	67,156	163,186	0	66,811	33,907	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	86,978	504,301	77,816	206,468	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	835,905	2,679,873	265,840	968,171	424,875	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.02	19001	WORKPOWER/CORP HEALTH	0	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	918	0	0	0	0	192.00
192.01	19201	VI STA MEDICAL CENTER EAST	2,556	221,787	0	90,803	0	192.01
194.00	07950	MARKETING	3	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	839,382	2,901,660	265,840	1,058,974	424,875	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet B  
Part I  
Date/Time Prepared:  
4/28/2016 11:04 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	0					11.00
13.00	01300	0	46,092				13.00
14.00	01400	0	0	0			14.00
15.00	01500	0	0	0	189,013		15.00
16.00	01600	0	0	0	0	80,550	16.00
17.00	01700	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	0	0	0	0	8,207	30.00
40.00	04000	0	23,046	0	0	14,095	40.00
41.00	04100	0	23,046	0	0	6,517	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
54.00	05400	0	0	0	0	9,710	54.00
54.01	05401	0	0	0	0	0	54.01
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	0	7,117	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	0	0	0	0	19	65.00
66.00	06600	0	0	0	0	5,825	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	189,013	5,113	73.00
76.00	03020	0	0	0	0	4,707	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	19,240	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
118.00		0	46,092	0	189,013	80,550	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.02	19001	0	0	0	0	0	190.02
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	0	0	0	0	0	194.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		0	46,092	0	189,013	80,550	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet B  
Part I  
Date/Time Prepared:  
4/28/2016 11:04 am

Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
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	0			17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	0	1,622,301	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	2,559,128	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	2,575,795	0	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	426,453	0	54.00
54.01	05401	ULTRA SOUND	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MRI	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	1,657,443	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	17,233	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,243,168	0	66.00
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	0	69.00
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	435,286	0	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0	1,443,323	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	0	2,329,273	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10	09910	CORF	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00	10900	PANCREAS ACQUISITION	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	14,309,403	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.02	19001	WORKPOWER/CORP HEALTH	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	16,058	0	192.00
192.01	19201	VISTA MEDICAL CENTER EAST	0	357,308	0	192.01
194.00	07950	MARKETING	0	53	0	194.00
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	14,682,822	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet B  
Part II  
Date/Time Prepared:  
4/28/2016 11:04 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	33,920	9,033	42,953	5.00
7.00 00700	OPERATION OF PLANT	0	541,727	144,267	685,994	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	11,775	3,136	14,911	8.00
9.00 00900	HOUSEKEEPING	0	26,510	7,060	33,570	9.00
10.00 01000	DIETARY	0	7,051	1,878	8,929	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	0	14,526	3,868	18,394	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	6,204	1,652	7,856	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	33,311	8,871	42,182	30.00
40.00 04000	SUBPROVIDER - I PF	0	48,676	12,963	61,639	40.00
41.00 04100	SUBPROVIDER - I RF	0	45,029	11,992	57,021	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	0	0	0	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01 05401	ULTRA SOUND	0	0	0	0	54.01
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MRI	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	0	30,383	8,091	38,474	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	21,028	5,600	26,628	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03020	MENTAL HEALTH ANCILLARY	0	19,826	5,280	25,106	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	61,269	16,317	77,586	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 09910	CORF	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	901,235	240,008	1,141,243	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.02 19001	WORKPOWER/CORP HEALTH	0	0	0	0	190.02
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01 19201	VI STA MEDICAL CENTER EAST	0	26,946	7,176	34,122	192.01
194.00 07950	MARKETING	0	0	0	0	194.00
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	928,181	247,184	1,175,365	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140033	Period: From 12/01/2014 To 11/30/2015	Worksheet B Part II Date/Time Prepared: 4/28/2016 11:04 am				
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	42,953				5.00	
7.00	00700	OPERATION OF PLANT	8,485	694,479			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	494	23,196	38,601		8.00	
9.00	00900	HOUSEKEEPING	2,460	52,224	0	88,254	9.00	
10.00	01000	DIETARY	1,004	13,890	0	1,980	25,803	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	135	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	60	28,615	0	4,079	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	25	12,222	0	1,742	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	3,468	65,622	6,143	9,355	0	30.00
40.00	04000	SUBPROVIDER - IPF	5,151	95,890	8,977	13,670	8,192	40.00
41.00	04100	SUBPROVIDER - IRF	5,005	88,706	8,304	12,646	15,552	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,219	0	0	0	0	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	3,797	59,853	0	8,533	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	50	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,828	41,425	3,878	5,906	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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	706	0	0	0	0	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	3,437	39,057	0	5,568	2,059	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	4,451	120,697	11,299	17,208	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	42,775	641,397	38,601	80,687	25,803	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.02	19001	WORKPOWER/CORP HEALTH	0	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	47	0	0	0	0	192.00
192.01	19201	VISTA MEDICAL CENTER EAST	131	53,082	0	7,567	0	192.01
194.00	07950	MARKETING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	42,953	694,479	38,601	88,254	25,803	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140033	Period: From 12/01/2014 To 11/30/2015	Worksheet B Part II Date/Time Prepared: 4/28/2016 11:04 am
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	0					11.00
13.00	01300	0	135				13.00
14.00	01400	0	0	0			14.00
15.00	01500	0	0	0	51,148		15.00
16.00	01600	0	0	0	0	21,845	16.00
17.00	01700	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	0	0	0	0	2,225	30.00
40.00	04000	0	67	0	0	3,821	40.00
41.00	04100	0	68	0	0	1,767	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
54.00	05400	0	0	0	0	2,632	54.00
54.01	05401	0	0	0	0	0	54.01
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	0	1,929	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	0	0	0	0	5	65.00
66.00	06600	0	0	0	0	1,579	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	51,148	1,386	73.00
76.00	03020	0	0	0	0	1,276	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	5,225	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
118.00		0	135	0	51,148	21,845	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.02	19001	0	0	0	0	0	190.02
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	0	0	0	0	0	194.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		0	135	0	51,148	21,845	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140033	Period: From 12/01/2014 To 11/30/2015	Worksheet B Part II Date/Time Prepared: 4/28/2016 11:04 am		
Cost Center	Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
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	0			17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	0	128,995	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	197,407	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	189,069	0	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,851	0	54.00
54.01	05401	ULTRA SOUND	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MRI	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	112,586	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	55	0	65.00
66.00	06600	PHYSICAL THERAPY	0	82,244	0	66.00
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	0	69.00
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	53,240	0	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0	76,503	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	0	236,466	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10	09910	CORF	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00	10900	PANCREAS ACQUISITION	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,080,416	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.02	19001	WORKPOWER/CORP HEALTH	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	47	0	192.00
192.01	19201	VISTA MEDICAL CENTER EAST	0	94,902	0	192.01
194.00	07950	MARKETING	0	0	0	194.00
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,175,365	0	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet B-1  
Date/Time Prepared:  
4/28/2016 11:04 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	230,101				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		230,101			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	7,166,050		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	8,409	8,409	128,984	-839,382	13,843,440
7.00 00700	OPERATION OF PLANT	134,297	134,297	272,381	0	2,735,780
8.00 00800	LAUNDRY & LINEN SERVICE	2,919	2,919	0	0	159,267
9.00 00900	HOUSEKEEPING	6,572	6,572	0	0	792,708
10.00 01000	DIETARY	1,748	1,748	0	0	323,464
11.00 01100	CAFETERIA	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	0	0	30,936	0	43,457
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00 01500	PHARMACY	3,601	3,601	0	0	19,332
16.00 01600	MEDICAL RECORDS & LIBRARY	1,538	1,538	0	0	8,089
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	8,258	8,258	882,216	0	1,117,590
40.00 04000	SUBPROVIDER - IPF	12,067	12,067	1,247,671	0	1,659,947
41.00 04100	SUBPROVIDER - IRF	11,163	11,163	1,173,268	0	1,612,805
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	0	0	0	0
51.00 05100	RECOVERY ROOM	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	228,130	0	392,919
54.01 05401	ULTRA SOUND	0	0	0	0	0
57.00 05700	CT SCAN	0	0	0	0	0
58.00 05800	MRI	0	0	0	0	0
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00 06000	LABORATORY	7,532	7,532	714,128	0	1,223,670
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	16,230
66.00 06600	PHYSICAL THERAPY	5,213	5,213	721,003	0	911,431
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	227,373
76.00 03020	MENTAL HEALTH ANCILLARY	4,915	4,915	798,839	0	1,107,556
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00 09000	CLINIC	0	0	0	0	0
91.00 09100	EMERGENCY	15,189	15,189	968,494	0	1,434,470
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 09910	CORF	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00 11100	ISLET ACQUISITION	0	0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1-117)	223,421	223,421	7,166,050	-839,382	13,786,088
<b>NONREIMBURSABLE COST CENTERS</b>						
190.02 19001	WORKPOWER/CORP HEALTH	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	15,140
192.01 19201	VISTA MEDICAL CENTER EAST	6,680	6,680	0	0	42,162
194.00 07950	MARKETING	0	0	0	0	50
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)	928,181	247,184	901,151		839,382
203.00	Unit cost multiplier (Wkst. B, Part I)	4.033798	1.074241	0.125753		0.060634
204.00	Cost to be allocated (per Wkst. B, Part II)			0		42,953
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.003103

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet B-1

Date/Time Prepared:  
4/28/2016 11:04 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)		
		7.00	8.00	9.00	10.00	11.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	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	87,395				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	2,919	161,198			8.00	
9.00	00900	HOUSEKEEPING	6,572	0	77,904		9.00	
10.00	01000	DIETARY	1,748	0	1,748	42,767	10.00	
11.00	01100	CAFETERIA	0	0	0	10,277	11.00	
13.00	01300	NURSING ADMINISTRATION	0	0	0	31	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00	
15.00	01500	PHARMACY	3,601	0	3,601	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	1,538	0	1,538	0	16.00	
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	8,258	25,654	8,258	0	1,462	30.00
40.00	04000	SUBPROVIDER - I PF	12,067	37,487	12,067	13,578	2,136	40.00
41.00	04100	SUBPROVIDER - I RF	11,163	34,678	11,163	25,776	1,585	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	299	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	7,532	0	7,532	0	1,355	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,213	16,194	5,213	0	960	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
76.00	03020	MENTAL HEALTH ANCILLARY	4,915	0	4,915	3,413	1,167	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	15,189	47,185	15,189	0	1,282	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	80,715	161,198	71,224	42,767	10,277	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.02	19001	WORKPOWER/CORP HEALTH	0	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	VI STA MEDICAL CENTER EAST	6,680	0	6,680	0	0	192.01
194.00	07950	MARKETING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,901,660	265,840	1,058,974	424,875	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	33.201671	1.649152	13.593320	9.934646	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	694,479	38,601	88,254	25,803	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.946439	0.239463	1.132856	0.603339	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet B-1

Date/Time Prepared:  
4/28/2016 11:04 am

Cost Center Description		NURSING ADMINISTRATION (DIRECT NRS G HR)	CENTRAL SERVICES & SUPPLY (COSTED REQ UIS)	PHARMACY (COSTED REQ UIS)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	SOCIAL SERVICE (PATIENT DA YS)	
		13.00	14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	47,489					13.00
14.00	01400	0	351,467				14.00
15.00	01500	0	938	227,373			15.00
16.00	01600	0	155	0	104,530,517		16.00
17.00	01700	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	0	10,588	0	10,644,092	0	30.00
40.00	04000	23,745	24,345	0	18,281,422	0	40.00
41.00	04100	23,744	43,353	0	8,452,403	0	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
54.00	05400	0	8,508	0	12,594,447	0	54.00
54.01	05401	0	0	0	0	0	54.01
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	160,405	0	9,230,626	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	0	0	0	24,080	0	65.00
66.00	06600	0	10,968	0	7,554,927	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	227,373	6,631,813	0	73.00
76.00	03020	0	0	0	6,104,628	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	92,207	0	25,012,079	0	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
118.00		47,489	351,467	227,373	104,530,517	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.02	19001	0	0	0	0	0	190.02
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00							201.00
202.00		46,092	0	189,013	80,550	0	202.00
203.00		0.970583	0.000000	0.831290	0.000771	0.000000	203.00
204.00		135	0	51,148	21,845	0	204.00
205.00		0.002843	0.000000	0.224952	0.000209	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet C  
Part I  
Date/Time Prepared:  
4/28/2016 11:04 am

		Title XVIII		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS		1,622,301	0	1,622,301	30.00	
40.00	04000 SUBPROVIDER - I PF		2,559,128	0	2,559,128	40.00	
41.00	04100 SUBPROVIDER - I RF		2,575,795	0	2,575,795	41.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM		0	0	0	50.00	
51.00	05100 RECOVERY ROOM		0	0	0	51.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC		426,453	0	426,453	54.00	
54.01	05401 ULTRA SOUND		0	0	0	54.01	
57.00	05700 CT SCAN		0	0	0	57.00	
58.00	05800 MRI		0	0	0	58.00	
59.00	05900 CARDIAC CATHETERIZATION		0	0	0	59.00	
60.00	06000 LABORATORY		1,657,443	0	1,657,443	60.00	
60.01	06001 BLOOD LABORATORY		0	0	0	60.01	
65.00	06500 RESPIRATORY THERAPY	0	17,233	0	17,233	65.00	
66.00	06600 PHYSICAL THERAPY	0	1,243,168	0	1,243,168	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	68.00	
69.00	06900 ELECTROCARDIOLOGY		0	0	0	69.00	
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		435,286	0	435,286	73.00	
76.00	03020 MENTAL HEALTH ANCILLARY		1,443,323	0	1,443,323	76.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC		0	0	0	88.00	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00	
90.00	09000 CLINIC		0	0	0	90.00	
91.00	09100 EMERGENCY		2,329,273	0	2,329,273	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910 CORF		0	0	0	99.10	
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900 PANCREAS ACQUISITION		0	0	0	109.00	
110.00	11000 INTESTINAL ACQUISITION		0	0	0	110.00	
111.00	11100 ISLET ACQUISITION		0	0	0	111.00	
200.00	Subtotal (see instructions)	0	14,309,403	0	14,309,403	200.00	
201.00	Less Observation Beds	0	0	0	0	201.00	
202.00	Total (see instructions)	0	14,309,403	0	14,309,403	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet C  
Part I  
Date/Time Prepared:  
4/28/2016 11:04 am

		Title XVIII			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	10,644,092		10,644,092		30.00
40.00	04000	SUBPROVIDER - I/PF	18,281,422		18,281,422		40.00
41.00	04100	SUBPROVIDER - I/RF	8,452,403		8,452,403		41.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	372,618	12,221,829	12,594,447	0.033860	54.00
54.01	05401	ULTRA SOUND	0	0	0	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	2,160,246	7,070,380	9,230,626	0.179559	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	16,663	7,417	24,080	0.715656	65.00
66.00	06600	PHYSICAL THERAPY	7,554,927	0	7,554,927	0.164551	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,618,188	2,013,625	6,631,813	0.065636	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	396,963	5,707,665	6,104,628	0.236431	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	2,535,384	22,476,695	25,012,079	0.093126	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0		99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
200.00		Subtotal (see instructions)	55,032,906	49,497,611	104,530,517		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	55,032,906	49,497,611	104,530,517		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140033	Period: From 12/01/2014 To 11/30/2015	Worksheet C Part I Date/Time Prepared: 4/28/2016 11:04 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
40.00	04000 SUBPROVIDER - I PF			40.00
41.00	04100 SUBPROVIDER - I RF			41.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.033860		54.00
54.01	05401 ULTRA SOUND	0.000000		54.01
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.179559		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
65.00	06500 RESPIRATORY THERAPY	0.715656		65.00
66.00	06600 PHYSICAL THERAPY	0.164551		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
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	0.065636		73.00
76.00	03020 MENTAL HEALTH ANCILLARY	0.236431		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.093126		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.10	09910 CORF			99.10
<b>SPECIAL PURPOSE COST CENTERS</b>				
109.00	10900 PANCREAS ACQUISITION			109.00
110.00	11000 INTESTINAL ACQUISITION			110.00
111.00	11100 ISLET ACQUISITION			111.00
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: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet C  
Part I  
Date/Time Prepared:  
4/28/2016 11:04 am

		Title XIX		Hospital		PPS		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs		
				Total Costs	RCE Disallowance			
		1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	1,622,301		1,622,301	0	1,622,301	30.00
40.00	04000	SUBPROVIDER - IPF	2,559,128		2,559,128	0	2,559,128	40.00
41.00	04100	SUBPROVIDER - IRF	2,575,795		2,575,795	0	2,575,795	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0		0	0	0	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	426,453		426,453	0	426,453	54.00
54.01	05401	ULTRA SOUND	0		0	0	0	54.01
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	1,657,443		1,657,443	0	1,657,443	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	17,233	0	17,233	0	17,233	65.00
66.00	06600	PHYSICAL THERAPY	1,243,168	0	1,243,168	0	1,243,168	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	435,286		435,286	0	435,286	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	1,443,323		1,443,323	0	1,443,323	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	2,329,273		2,329,273	0	2,329,273	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF	0		0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>								
109.00	10900	PANCREAS ACQUISITION	0		0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0		0	0	0	111.00
200.00		Subtotal (see instructions)	14,309,403	0	14,309,403	0	14,309,403	200.00
201.00		Less Observation Beds	0		0	0	0	201.00
202.00		Total (see instructions)	14,309,403	0	14,309,403	0	14,309,403	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet C  
Part I  
Date/Time Prepared:  
4/28/2016 11:04 am

		Title XIX			Hospital	PPS
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	10,644,092		10,644,092	30.00
40.00	04000	SUBPROVIDER - I/PF	18,281,422		18,281,422	40.00
41.00	04100	SUBPROVIDER - I/RF	8,452,403		8,452,403	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	372,618	12,221,829	12,594,447	54.00
54.01	05401	ULTRA SOUND	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MRI	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	2,160,246	7,070,380	9,230,626	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	16,663	7,417	24,080	65.00
66.00	06600	PHYSICAL THERAPY	7,554,927	0	7,554,927	66.00
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	0	69.00
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	4,618,188	2,013,625	6,631,813	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	396,963	5,707,665	6,104,628	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	2,535,384	22,476,695	25,012,079	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10	09910	CORF	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00	10900	PANCREAS ACQUISITION	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	111.00
200.00		Subtotal (see instructions)	55,032,906	49,497,611	104,530,517	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	55,032,906	49,497,611	104,530,517	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140033	Period: From 12/01/2014 To 11/30/2015	Worksheet C Part I Date/Time Prepared: 4/28/2016 11:04 am
		Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
40.00	04000 SUBPROVIDER - I PF			40.00
41.00	04100 SUBPROVIDER - I RF			41.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.033860		54.00
54.01	05401 ULTRA SOUND	0.000000		54.01
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.179559		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
65.00	06500 RESPIRATORY THERAPY	0.715656		65.00
66.00	06600 PHYSICAL THERAPY	0.164551		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
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	0.065636		73.00
76.00	03020 MENTAL HEALTH ANCILLARY	0.236431		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.093126		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.10	09910 CORF			99.10
<b>SPECIAL PURPOSE COST CENTERS</b>				
109.00	10900 PANCREAS ACQUISITION			109.00
110.00	11000 INTESTINAL ACQUISITION			110.00
111.00	11100 ISLET ACQUISITION			111.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 140033

Period: From 12/01/2014 To 11/30/2015

Worksheet C Part II Date/Time Prepared: 4/28/2016 11:04 am

Cost Center Description		Title XIX			Hospital	PPS	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	426,453	3,851	422,602	0	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	1,657,443	112,586	1,544,857	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	17,233	55	17,178	0	65.00
66.00	06600	PHYSICAL THERAPY	1,243,168	82,244	1,160,924	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	435,286	53,240	382,046	0	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	1,443,323	76,503	1,366,820	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,329,273	236,466	2,092,807	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
200.00		Subtotal (sum of lines 50 thru 199)	7,552,179	564,945	6,987,234	0	200.00
201.00		Less Observation Beds	0	0	0	0	201.00
202.00		Total (line 200 minus line 201)	7,552,179	564,945	6,987,234	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 140033

Period: From 12/01/2014 To 11/30/2015

Worksheet C Part II Date/Time Prepared: 4/28/2016 11:04 am

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
		6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0.000000	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	426,453	12,594,447	0.033860	54.00
54.01	05401 ULTRA SOUND	0	0	0.000000	54.01
57.00	05700 CT SCAN	0	0	0.000000	57.00
58.00	05800 MRI	0	0	0.000000	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	59.00
60.00	06000 LABORATORY	1,657,443	9,230,626	0.179559	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	60.01
65.00	06500 RESPIRATORY THERAPY	17,233	24,080	0.715656	65.00
66.00	06600 PHYSICAL THERAPY	1,243,168	7,554,927	0.164551	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	435,286	6,631,813	0.065636	73.00
76.00	03020 MENTAL HEALTH ANCILLARY	1,443,323	6,104,628	0.236431	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	89.00
90.00	09000 CLINIC	0	0	0.000000	90.00
91.00	09100 EMERGENCY	2,329,273	25,012,079	0.093126	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910 CORF	0	0	0.000000	99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900 PANCREAS ACQUISITION	0	0	0.000000	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0.000000	110.00
111.00	11100 ISLET ACQUISITION	0	0	0.000000	111.00
200.00	Subtotal (sum of lines 50 thru 199)	7,552,179	67,152,600		200.00
201.00	Less Observation Beds	0	0		201.00
202.00	Total (line 200 minus line 201)	7,552,179	67,152,600		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140033		Period: From 12/01/2014 To 11/30/2015		Worksheet D Part I Date/Time Prepared: 4/28/2016 11:04 am		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	128,995	0	128,995	3,302	39.07	30.00	
40.00	SUBPROVIDER - IPF	197,407	0	197,407	5,606	35.21	40.00	
41.00	SUBPROVIDER - IRF	189,069	0	189,069	3,497	54.07	41.00	
200.00	Total (Lines 30-199)	515,471		515,471	12,405		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	119	4,649					30.00
40.00	SUBPROVIDER - IPF	1,034	36,407					40.00
41.00	SUBPROVIDER - IRF	1,963	106,139					41.00
200.00	Total (Lines 30-199)	3,116	147,195					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet D  
Part II  
Date/Time Prepared:  
4/28/2016 11:04 am

Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0.000000	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,851	12,594,447	0.000306	0	0	54.00
54.01	05401	ULTRA SOUND	0	0	0.000000	0	0	54.01
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	112,586	9,230,626	0.012197	35,035	427	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	55	24,080	0.002284	0	0	65.00
66.00	06600	PHYSICAL THERAPY	82,244	7,554,927	0.010886	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	53,240	6,631,813	0.008028	43,244	347	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	76,503	6,104,628	0.012532	5,107	64	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	236,466	25,012,079	0.009454	24,813	235	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
200.00		Total (lines 50-199)	564,945	67,152,600		108,199	1,073	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140033		Period: From 12/01/2014 To 11/30/2015		Worksheet D Part III Date/Time Prepared: 4/28/2016 11:04 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,302	0.00	119	0		30.00
40.00	04000	SUBPROVIDER - IPF	5,606	0.00	1,034	0		40.00
41.00	04100	SUBPROVIDER - IRF	3,497	0.00	1,963	0		41.00
200.00		Total (lines 30-199)	12,405		3,116	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet D  
Part IV  
Date/Time Prepared:  
4/28/2016 11:04 am

Cost Center Description		Title XVIII				Hospital	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet D  
Part IV  
Date/Time Prepared:  
4/28/2016 11:04 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,594,447	0.000000	0.000000	0	54.00
54.01	05401	ULTRA SOUND	0	0	0.000000	0.000000	0	54.01
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	9,230,626	0.000000	0.000000	35,035	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	24,080	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	7,554,927	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,631,813	0.000000	0.000000	43,244	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0	6,104,628	0.000000	0.000000	5,107	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	25,012,079	0.000000	0.000000	24,813	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	67,152,600			108,199	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet D  
Part IV  
Date/Time Prepared:  
4/28/2016 11:04 am

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
Title XVIII Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	805,581	0	54.00
54.01	05401 ULTRA SOUND	0	0	0	54.01
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MRI	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	339,911	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	571	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
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	0	69.00
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	124,291	0	73.00
76.00	03020 MENTAL HEALTH ANCILLARY	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	90.00
91.00	09100 EMERGENCY	0	1,429,652	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
200.00	Total (lines 50-199)	0	2,700,006	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet D  
Part V  
Date/Time Prepared:  
4/28/2016 11:04 am

		Title XVIII		Hospital		PPS	
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.033860	805,581	0	0	27,277	54.00
54.01	05401 ULTRA SOUND	0.000000	0	0	0	0	54.01
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 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	0.179559	339,911	0	0	61,034	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.715656	571	0	0	409	65.00
66.00	06600 PHYSICAL THERAPY	0.164551	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
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	0.065636	124,291	0	0	8,158	73.00
76.00	03020 MENTAL HEALTH ANCILLARY	0.236431	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.093126	1,429,652	0	0	133,138	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00	Subtotal (see instructions)		2,700,006	0	0	230,016	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		2,700,006	0	0	230,016	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140033	Period: From 12/01/2014 To 11/30/2015	Worksheet D Part V Date/Time Prepared: 4/28/2016 11:04 am
		Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401 ULTRA SOUND	0	0	54.01
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
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
76.00	03020 MENTAL HEALTH ANCILLARY	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00	Subtotal (see instructions)	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140033 Component CCN: 14S033		Period: From 12/01/2014 To 11/30/2015		Worksheet D Part II Date/Time Prepared: 4/28/2016 11:04 am		
		Title XVIII		Subprovider - IPF		PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0.000000	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,851	12,594,447	0.000306	58,838	18	54.00
54.01	05401	ULTRA SOUND	0	0	0.000000	0	0	54.01
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	112,586	9,230,626	0.012197	241,166	2,942	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	55	24,080	0.002284	0	0	65.00
66.00	06600	PHYSICAL THERAPY	82,244	7,554,927	0.010886	1,347	15	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	53,240	6,631,813	0.008028	404,600	3,248	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	76,503	6,104,628	0.012532	59,999	752	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	236,466	25,012,079	0.009454	300,003	2,836	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
200.00		Total (lines 50-199)	564,945	67,152,600		1,065,953	9,811	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140033 Component CCN: 14S033	Period: From 12/01/2014 To 11/30/2015	Worksheet D Part IV Date/Time Prepared: 4/28/2016 11:04 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01 05401 ULTRA SOUND	0	0	0	0	0	54.01
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 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
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
76.00 03020 MENTAL HEALTH ANCILLARY	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140033 Component CCN: 14S033	Period: From 12/01/2014 To 11/30/2015	Worksheet D Part IV Date/Time Prepared: 4/28/2016 11:04 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0.000000	0.000000	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	12,594,447	0.000000	0.000000	58,838	54.00
54.01	05401 ULTRA SOUND	0	0	0.000000	0.000000	0	54.01
57.00	05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800 MRI	0	0	0.000000	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	9,230,626	0.000000	0.000000	241,166	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	24,080	0.000000	0.000000	0	65.00
66.00	06600 PHYSICAL THERAPY	0	7,554,927	0.000000	0.000000	1,347	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.000000	0.000000	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	6,631,813	0.000000	0.000000	404,600	73.00
76.00	03020 MENTAL HEALTH ANCILLARY	0	6,104,628	0.000000	0.000000	59,999	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000 CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	25,012,079	0.000000	0.000000	300,003	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	67,152,600			1,065,953	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140033 Component CCN: 14S033	Period: From 12/01/2014 To 11/30/2015	Worksheet D Part IV Date/Time Prepared: 4/28/2016 11:04 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01	05401 ULTRA SOUND	0	0	0	54.01
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MRI	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
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	0	69.00
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
76.00	03020 MENTAL HEALTH ANCILLARY	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140033 Component CCN: 14T033		Period: From 12/01/2014 To 11/30/2015		Worksheet D Part II Date/Time Prepared: 4/28/2016 11:04 am		
		Title XVIII		Subprovider - IRF		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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0.000000	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,851	12,594,447	0.000306	83,297	25	54.00
54.01	05401	ULTRA SOUND	0	0	0.000000	0	0	54.01
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	112,586	9,230,626	0.012197	482,901	5,890	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	55	24,080	0.002284	16,484	38	65.00
66.00	06600	PHYSICAL THERAPY	82,244	7,554,927	0.010886	4,244,414	46,205	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	53,240	6,631,813	0.008028	1,121,066	9,000	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	76,503	6,104,628	0.012532	2,739	34	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	236,466	25,012,079	0.009454	137,143	1,297	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
200.00		Total (lines 50-199)	564,945	67,152,600		6,088,044	62,489	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140033 Component CCN: 14T033	Period: From 12/01/2014 To 11/30/2015	Worksheet D Part IV Date/Time Prepared: 4/28/2016 11:04 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 ULTRA SOUND	0	0	0	0	0	54.01
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 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
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
76.00	03020 MENTAL HEALTH ANCILLARY	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140033 Component CCN: 14T033	Period: From 12/01/2014 To 11/30/2015	Worksheet D Part IV Date/Time Prepared: 4/28/2016 11:04 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	0	0.000000	0.000000	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	12,594,447	0.000000	0.000000	83,297	54.00
54.01 05401 ULTRA SOUND	0	0	0.000000	0.000000	0	54.01
57.00 05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00 05800 MRI	0	0	0.000000	0.000000	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00 06000 LABORATORY	0	9,230,626	0.000000	0.000000	482,901	60.00
60.01 06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00 06500 RESPIRATORY THERAPY	0	24,080	0.000000	0.000000	16,484	65.00
66.00 06600 PHYSICAL THERAPY	0	7,554,927	0.000000	0.000000	4,244,414	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.000000	0.000000	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	6,631,813	0.000000	0.000000	1,121,066	73.00
76.00 03020 MENTAL HEALTH ANCILLARY	0	6,104,628	0.000000	0.000000	2,739	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00 09000 CLINIC	0	0	0.000000	0.000000	0	90.00
91.00 09100 EMERGENCY	0	25,012,079	0.000000	0.000000	137,143	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0.000000	0	92.00
200.00 Total (lines 50-199)	0	67,152,600			6,088,044	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140033 Component CCN: 14T033	Period: From 12/01/2014 To 11/30/2015	Worksheet D Part IV Date/Time Prepared: 4/28/2016 11:04 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01	05401 ULTRA SOUND	0	0	0	54.01
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MRI	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
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	0	69.00
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
76.00	03020 MENTAL HEALTH ANCILLARY	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140033		Period: From 12/01/2014 To 11/30/2015		Worksheet D Part I Date/Time Prepared: 4/28/2016 11:04 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4) PPS	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	128,995	0	128,995	3,302	39.07	30.00
40.00	SUBPROVIDER - IPF	197,407	0	197,407	5,606	35.21	40.00
41.00	SUBPROVIDER - IRF	189,069	0	189,069	3,497	54.07	41.00
200.00	Total (Lines 30-199)	515,471		515,471	12,405		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	2,178	85,094				
40.00	SUBPROVIDER - IPF	2,639	92,919				
41.00	SUBPROVIDER - IRF	466	25,197				
200.00	Total (Lines 30-199)	5,283	203,210				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet D  
Part II  
Date/Time Prepared:  
4/28/2016 11:04 am

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)	Title XIX		Hospital	
					Inpatient Program Charges	Capital Costs (column 3 x column 4)	PPS	
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0.000000	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,851	12,594,447	0.000306	0	0	54.00
54.01	05401	ULTRA SOUND	0	0	0.000000	0	0	54.01
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	112,586	9,230,626	0.012197	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	55	24,080	0.002284	0	0	65.00
66.00	06600	PHYSICAL THERAPY	82,244	7,554,927	0.010886	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	53,240	6,631,813	0.008028	0	0	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	76,503	6,104,628	0.012532	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	236,466	25,012,079	0.009454	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
200.00		Total (lines 50-199)	564,945	67,152,600		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140033		Period: From 12/01/2014 To 11/30/2015		Worksheet D Part III Date/Time Prepared: 4/28/2016 11:04 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,302	0.00	2,178	0		30.00
40.00	04000	SUBPROVIDER - IPF	5,606	0.00	2,639	0		40.00
41.00	04100	SUBPROVIDER - IRF	3,497	0.00	466	0		41.00
200.00		Total (lines 30-199)	12,405		5,283	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet D  
Part IV  
Date/Time Prepared:  
4/28/2016 11:04 am

Cost Center Description		Title XIX			Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost			
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	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
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
76.00	03020	MENTAL HEALTH ANCILLARY	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet D  
Part IV  
Date/Time Prepared:  
4/28/2016 11:04 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,594,447	0.000000	0.000000	0	54.00
54.01	05401	ULTRA SOUND	0	0	0.000000	0.000000	0	54.01
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	9,230,626	0.000000	0.000000	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	24,080	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	7,554,927	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,631,813	0.000000	0.000000	0	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0	6,104,628	0.000000	0.000000	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	25,012,079	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	67,152,600			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140033	Period: From 12/01/2014 To 11/30/2015	Worksheet D Part IV Date/Time Prepared: 4/28/2016 11:04 am
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
Title XIX Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01	05401 ULTRA SOUND	0	0	0	54.01
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MRI	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
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	0	69.00
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
76.00	03020 MENTAL HEALTH ANCILLARY	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140033	Period: From 12/01/2014 To 11/30/2015	Worksheet D-1 Date/Time Prepared: 4/28/2016 11:04 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,302	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,302	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)		3,302	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)		119	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,622,301	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)		1,622,301	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,622,301	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		491.31	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		58,466	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)		58,466	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140033		Period: From 12/01/2014 To 11/30/2015		Worksheet D-1 Date/Time Prepared: 4/28/2016 11:04 am	
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)	
NURSERY (title V & XIX only)		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)					12,647	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					71,113	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)					4,649	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,073	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					5,722	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					65,391	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: 140033		Period: From 12/01/2014 To 11/30/2015		Worksheet D-1 Date/Time Prepared: 4/28/2016 11:04 am	
Cost Center Description		Cost	Routine Cost (from line 27)	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	128,995	1,622,301	0.079514	0	0	90.00
91.00	Nursing School cost	0	1,622,301	0.000000	0	0	91.00
92.00	Allied health cost	0	1,622,301	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,622,301	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140033	Period: From 12/01/2014 To 11/30/2015	Worksheet D-1
		Component CCN: 14S033		Date/Time Prepared: 4/28/2016 11:04 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,606	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,606	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)		5,606	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)		1,034	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,559,128	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)		2,559,128	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,559,128	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		456.50	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		472,021	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)		472,021	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140033	Period: From 12/01/2014 To 11/30/2015	Worksheet D-1			
		Component CCN: 14S033		Date/Time Prepared: 4/28/2016 11:04 am			
		Title XVIII	Subprovider - IPF	PPS			
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)					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)					114,198	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					586,219	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)					36,407	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					9,811	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					46,218	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					540,001	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: 140033 Component CCN: 14S033		Period: From 12/01/2014 To 11/30/2015		Worksheet D-1 Date/Time Prepared: 4/28/2016 11:04 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	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	197,407	2,559,128	0.077138	0	0	90.00
91.00	Nursing School cost	0	2,559,128	0.000000	0	0	91.00
92.00	Allied health cost	0	2,559,128	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,559,128	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140033	Period: From 12/01/2014 To 11/30/2015	Worksheet D-1
		Component CCN: 14T033		Date/Time Prepared: 4/28/2016 11:04 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,497	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,497	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)		3,497	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)		1,963	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,575,795	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)		2,575,795	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,575,795	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		736.57	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,445,887	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)		1,445,887	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140033	Period: From 12/01/2014 To 11/30/2015	Worksheet D-1			
		Component CCN: 14T033		Date/Time Prepared: 4/28/2016 11:04 am			
		Title XVIII	Subprovider - IRF	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)					886,751	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,332,638	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)					106,139	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					62,489	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					168,628	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,164,010	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: 140033 Component CCN: 14T033		Period: From 12/01/2014 To 11/30/2015		Worksheet D-1 Date/Time Prepared: 4/28/2016 11:04 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	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	189,069	2,575,795	0.073402	0	0	90.00
91.00	Nursing School cost	0	2,575,795	0.000000	0	0	91.00
92.00	Allied health cost	0	2,575,795	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,575,795	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140033	Period: From 12/01/2014 To 11/30/2015	Worksheet D-1 Date/Time Prepared: 4/28/2016 11:04 am
		Title XIX	Hospital	PPS
Cost Center Description		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,302	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,302	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)		3,302	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)		2,178	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,622,301	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)		1,622,301	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,622,301	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		491.31	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,070,073	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)		1,070,073	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 140033	Period: From 12/01/2014 To 11/30/2015	Worksheet D-1 Date/Time Prepared: 4/28/2016 11:04 am
Cost Center Description			Title XIX	Hospital	PPS
	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)				0 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				1,070,073 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)				85,094 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)				85,094 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				984,979 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: 140033		Period: From 12/01/2014 To 11/30/2015		Worksheet D-1 Date/Time Prepared: 4/28/2016 11:04 am	
Cost Center Description		Cost	Routine Cost (from line 27)	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	128,995	1,622,301	0.079514	0	0	90.00
91.00	Nursing School cost	0	1,622,301	0.000000	0	0	91.00
92.00	Allied health cost	0	1,622,301	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,622,301	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140033	Period: From 12/01/2014 To 11/30/2015	Worksheet D-3 Date/Time Prepared: 4/28/2016 11:04 am
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		374,419		30.00
40.00	04000 SUBPROVIDER - I/P		0		40.00
41.00	04100 SUBPROVIDER - I/R		0		41.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.000000	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.033860	0	0	54.00
54.01	05401 ULTRA SOUND	0.000000	0	0	54.01
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MRI	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.179559	35,035	6,291	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.715656	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.164551	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.065636	43,244	2,838	73.00
76.00	03020 MENTAL HEALTH ANCILLARY	0.236431	5,107	1,207	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.093126	24,813	2,311	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		108,199	12,647	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)		108,199		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140033	Period: From 12/01/2014 To 11/30/2015	Worksheet D-3	
		Component CCN: 14S033		Date/Time Prepared: 4/28/2016 11:04 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS			30.00
40.00	04000	SUBPROVIDER - IPF		3,355,062	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.033860	58,838	54.00
54.01	05401	ULTRA SOUND	0.000000	0	54.01
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MRI	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.179559	241,166	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.715656	0	65.00
66.00	06600	PHYSICAL THERAPY	0.164551	1,347	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.065636	404,600	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0.236431	59,999	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.000000	0	90.00
91.00	09100	EMERGENCY	0.093126	300,003	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,065,953	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)		1,065,953	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140033 Component CCN: 14T033	Period: From 12/01/2014 To 11/30/2015	Worksheet D-3 Date/Time Prepared: 4/28/2016 11:04 am
		Title XVIII	Subprovider - IRF	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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
40.00	04000 SUBPROVIDER - I PF		0	40.00
41.00	04100 SUBPROVIDER - IRF		4,796,744	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.000000	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.033860	83,297	54.00
54.01	05401 ULTRA SOUND	0.000000	0	54.01
57.00	05700 CT SCAN	0.000000	0	57.00
58.00	05800 MRI	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000 LABORATORY	0.179559	482,901	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.715656	16,484	65.00
66.00	06600 PHYSICAL THERAPY	0.164551	4,244,414	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.065636	1,121,066	73.00
76.00	03020 MENTAL HEALTH ANCILLARY	0.236431	2,739	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000 CLINIC	0.000000	0	90.00
91.00	09100 EMERGENCY	0.093126	137,143	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		6,088,044	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)		6,088,044	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140033	Period: From 12/01/2014 To 11/30/2015	Worksheet E Part A Date/Time Prepared: 4/28/2016 11:04 am	
		Title XVIII	Hospital		PPS
		0	before 1/1	on/after 1/1	2.00
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS</b>					
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)		71,072		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		14,214		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)		0		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		0		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		16.00		4.00
<b>Indirect Medical Education Adjustment</b>					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00		7.00
7.01	ACA Section 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 section 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 section 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.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		0.00		12.00
13.00	Total allowable FTE count for the prior year.		0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00		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		0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21.00
22.00	IME payment adjustment (see instructions)		0		22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0		22.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 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)		0		29.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140033	Period: From 12/01/2014 To 11/30/2015	Worksheet E Part A Date/Time Prepared: 4/28/2016 11:04 am	
		Title XVIII	Hospital	PPS	
		0	before 1/1	on/after 1/1	2.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	1.01	29.01
<b>Disproportionate Share Adjustment</b>					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		0.00		30.00
31.00	Percentage of Medicaid patient days (see instructions)		65.96		31.00
32.00	Sum of lines 30 and 31		65.96		32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.00		33.00
34.00	Disproportionate share adjustment (see instructions)		2,559		34.00
			Prior to October 1	On/After October 1	
		0	1.00	1.01	2.00
<b>Uncompensated Care Adjustment</b>					
35.00	Total uncompensated care amount (see instructions)		7,647,644,885	6,406,145,534	35.00
35.01	Factor 3 (see instructions)		0.000067398	0.000066901	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		515,436	428,578	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		429,295	71,430	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		500,725		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)</b>					
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 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	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 and 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	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)		588,570		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
49.00	Total payment for inpatient operating costs (see instructions)		588,570		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		6,815		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).		0		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
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 instructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		595,385		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		595,385		61.00
62.00	Deductibles billed to program beneficiaries		19,984		62.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet E  
Part A  
Date/Time Prepared:  
4/28/2016 11:04 am

		Title XVIII		Hospital	PPS
		0	Prior to October 1 1.00	1.01	On/After October 1 2.00
63.00	Coinsurance billed to program beneficiaries		0		63.00
64.00	Allowable bad debts (see instructions)		0		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		0		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		575,401		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	ADJUSTMENT FOR CORRECTION TO CLAIMS		-503,284		70.00
70.50	RURAL DEMONSTRATION PROJECT		0		70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		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)		0		70.94
70.95	Recovery of accelerated depreciation		0		70.95
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)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		72,117		71.00
71.01	Sequestration adjustment (see instructions)		1,442		71.01
72.00	Interim payments		79,324		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, 72, and 73)		-8,649		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		171,677		75.00
<b>TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)</b>					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. 1, 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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140033	Period: From 12/01/2014 To 11/30/2015	Worksheet E Part A Date/Time Prepared: 4/28/2016 11:04 am
		Title XVIII	Hospital	PPS
		Prior to 10/1		On/After 10/1
		1.00	1.01	2.00
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)	0		0 100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000		0.0000000000 101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0		0 102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000		0.0000 103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0		0 104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140033	Period: From 12/01/2014 To 11/30/2015	Worksheet E Part B Date/Time Prepared: 4/28/2016 11:04 am
		Title XVII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		230,016	2.00
3.00	PPS payments		273,235	3.00
4.00	Outlier payment (see instructions)		0	4.00
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 line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH 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, 8 and 9)		273,235	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		61,863	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)		211,372	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)		211,372	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		211,372	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		46,223	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		30,045	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		36,982	36.00
37.00	Subtotal (see instructions)		241,417	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	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)		241,417	40.00
40.01	Sequestration adjustment (see instructions)		4,828	40.01
41.00	Interim payments		207,074	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		29,515	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140033	Period: From 12/01/2014 To 11/30/2015	Worksheet E Part B Date/Time Prepared: 4/28/2016 11:04 am
		Component CCN: 14S033	Title XVII	Subprovider - IPF
		PPS		
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments		26,586	3.00
4.00	Outlier payment (see instructions)		0	4.00
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 line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH 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, 8 and 9)		26,586	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		5,348	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)		21,238	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)		21,238	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		21,238	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		21,238	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	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)		21,238	40.00
40.01	Sequestration adjustment (see instructions)		425	40.01
41.00	Interim payments		20,814	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-1	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140033	Period: From 12/01/2014 To 11/30/2015	Worksheet E Part B Date/Time Prepared: 4/28/2016 11:04 am
		Component CCN: 14T033	Title XVII I	Subprovider - IRF
		PPS		
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments		7,853	3.00
4.00	Outlier payment (see instructions)		0	4.00
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 line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH 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, 8 and 9)		7,853	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		7,853	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)		7,853	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		7,853	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		7,853	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	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)		7,853	40.00
40.01	Sequestration adjustment (see instructions)		157	40.01
41.00	Interim payments		6,171	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		1,525	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet E-1  
Part I  
Date/Time Prepared:  
4/28/2016 11:04 am

Title XVIII

Hospital

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		79,324		207,074	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)		79,324		207,074	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		29,515	6.01
6.02	SETTLEMENT TO PROGRAM		8,649		0	6.02
7.00	Total Medicare program liability (see instructions)		70,675		236,589	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: 140033  
Component CCN: 14S033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet E-1  
Part I  
Date/Time Prepared:  
4/28/2016 11:04 am

Title XVIII

Subprovider -  
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		854,540		20,814	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)		854,540		20,814	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		22,001		1	6.02
7.00	Total Medicare program liability (see instructions)		832,539		20,813	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: 140033  
Component CCN: 14T033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet E-1  
Part I  
Date/Time Prepared:  
4/28/2016 11:04 am

Title XVIII

Subprovider -  
IRF

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					1.00
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		2,859,288		6,171	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)		0		0	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)		2,859,288		6,171	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		22,102		1,525	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,881,390		7,696	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: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet E-1  
Part II  
Date/Time Prepared:  
4/28/2016 11:04 am

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	462	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	119	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	15	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	3,302	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	104,530,517	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	633,908	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	61,200	8.00
9.00	Sequestration adjustment amount (see instructions)	1,224	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	59,976	10.00
<b>INPATIENT HOSPITAL SERVICES UNDER THE IPPS &amp; CAH</b>			
30.00	Initial/interim HIT payment adjustment (see instructions)	212,660	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	-152,684	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140033	Period: From 12/01/2014 To 11/30/2015	Worksheet E-3 Part II Date/Time Prepared: 4/28/2016 11:04 am
		Component CCN: 14S033	Title XVII I	Subprovider - IPF
		PPS		
		1.00		
<b>PART II - MEDICARE PART A SERVICES - IPF PPS</b>				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		888,961	1.00
2.00	Net IPF PPS Outlier Payments		0	2.00
3.00	Net IPF PPS ECT Payments		0	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 instructions)		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 instructions)		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)		15.358904	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$ .		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)		888,961	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)		888,961	16.00
17.00	Primary payer payments		540	17.00
18.00	Subtotal (line 16 less line 17).		888,421	18.00
19.00	Deductibles		119,392	19.00
20.00	Subtotal (line 18 minus line 19)		769,029	20.00
21.00	Coinsurance		2,520	21.00
22.00	Subtotal (line 20 minus line 21)		766,509	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		127,725	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		83,021	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		94,202	25.00
26.00	Subtotal (sum of lines 22 and 24)		849,530	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)		0	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	Recovery of Accelerated Depreciation		0	30.99
31.00	Total amount payable to the provider (see instructions)		849,530	31.00
31.01	Sequestration adjustment (see instructions)		16,991	31.01
32.00	Interim payments		854,540	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, 32 and 33)		-22,001	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	35.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		0	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: 140033 Component CCN: 14T033	Period: From 12/01/2014 To 11/30/2015	Worksheet E-3 Part III Date/Time Prepared: 4/28/2016 11:04 am
		Title XVIIII	Subprovider - IRF	PPS
				1.00
<b>PART III - MEDICARE PART A SERVICES - IRF PPS</b>				
1.00	Net Federal PPS Payment (see instructions)			2,820,806 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0349 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			114,525 3.00
4.00	Outlier Payments			29,076 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	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 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			9.580822 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			2,964,407 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			2,964,407 17.00
18.00	Primary payer payments			14,070 18.00
19.00	Subtotal (line 17 less line 18).			2,950,337 19.00
20.00	Deductibles			8,820 20.00
21.00	Subtotal (line 19 minus line 20)			2,941,517 21.00
22.00	Coinsurance			3,780 22.00
23.00	Subtotal (line 21 minus line 22)			2,937,737 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			3,780 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			2,457 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			3,780 26.00
27.00	Subtotal (sum of lines 23 and 25)			2,940,194 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Recovery of Accelerated Depreciation			0 31.99
32.00	Total amount payable to the provider (see instructions)			2,940,194 32.00
32.01	Sequestration adjustment (see instructions)			58,804 32.01
33.00	Interim payments			2,859,288 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 33, and 34)			22,102 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			29,076 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

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

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet G

Date/Time Prepared:  
4/28/2016 11:04 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	1,621	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	5,852,182	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,989,310	0	0	0	6.00
7.00	Inventory	206,909	0	0	0	7.00
8.00	Prepaid expenses	41,974	0	0	0	8.00
9.00	Other current assets	875,957	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)	4,989,333	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	4,217,077	0	0	0	12.00
13.00	Land improvements	4,304,292	0	0	0	13.00
14.00	Accumulated depreciation	-2,196,491	0	0	0	14.00
15.00	Buildings	13,181,395	0	0	0	15.00
16.00	Accumulated depreciation	-3,287,189	0	0	0	16.00
17.00	Leasehold improvements	1,247,518	0	0	0	17.00
18.00	Accumulated depreciation	-734,145	0	0	0	18.00
19.00	Fixed equipment	1,256,423	0	0	0	19.00
20.00	Accumulated depreciation	-458,940	0	0	0	20.00
21.00	Automobiles and trucks	22,569	0	0	0	21.00
22.00	Accumulated depreciation	-22,569	0	0	0	22.00
23.00	Major movable equipment	2,135,133	0	0	0	23.00
24.00	Accumulated depreciation	-2,043,771	0	0	0	24.00
25.00	Minor equipment depreciable	1,388,500	0	0	0	25.00
26.00	Accumulated depreciation	-1,354,581	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)	17,655,221	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	-166,567	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	-166,567	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	22,477,987	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	998,326	0	0	0	37.00
38.00	Salaries, wages, and fees payable	643,416	0	0	0	38.00
39.00	Payroll taxes payable	68,848	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	-17,013,022	0	0	0	43.00
44.00	Other current liabilities	679,342	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-14,623,090	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-14,623,090	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	37,101,077				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	37,101,077	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	22,477,987	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet G-1

Date/Time Prepared:  
4/28/2016 11:04 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		30,683,281		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		6,417,796			2.00
3.00	Total (sum of line 1 and line 2)		37,101,077		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		37,101,077		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		37,101,077		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
4/28/2016 11:04 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	10,644,092		10,644,092	1.00
2.00	SUBPROVIDER - IPF	18,281,422		18,281,422	2.00
3.00	SUBPROVIDER - IRF	8,452,403		8,452,403	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				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)	37,377,917		37,377,917	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	37,377,917		37,377,917	17.00
18.00	Ancillary services	15,119,605	27,020,916	42,140,521	18.00
19.00	Outpatient services	2,535,384	22,476,695	25,012,079	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
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	55,032,906	49,497,611	104,530,517	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		18,595,695		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)		18,595,695		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140033

Period:  
From 12/01/2014  
To 11/30/2015

Worksheet G-3

Date/Time Prepared:  
4/28/2016 11:04 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	104,530,517	1.00
2.00	Less contractual allowances and discounts on patients' accounts	80,109,066	2.00
3.00	Net patient revenues (line 1 minus line 2)	24,421,451	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	18,595,695	4.00
5.00	Net income from service to patients (line 3 minus line 4)	5,825,756	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	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	0	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	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	592,040	24.00
25.00	Total other income (sum of lines 6-24)	592,040	25.00
26.00	Total (line 5 plus line 25)	6,417,796	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	6,417,796	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140033	Period: From 12/01/2014 To 11/30/2015	Worksheet L Parts I-III Date/Time Prepared: 4/28/2016 11:04 am
		Title XVII	Hospital	PPS
		1.00		
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		6,815	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		0	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)		9.05	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	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)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		6,815	12.00
		1.00		
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
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		
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
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