

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0033	Period: From 12/01/2016 To 11/30/2017	Worksheet S Parts I-III Date/Time Prepared: 4/30/2018 2:19 pm
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**PART I - COST REPORT STATUS**

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: 4/30/2018 Time: 2:19 pm
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 CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by VISTA MEDICAL CENTER WEST ( 14-0033 ) for the cost reporting period beginning 12/01/2016 and ending 11/30/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	0	31,451	0	0	1.00
2.00 Subprovider - IPF	0	-4,383	0		0	2.00
3.00 Subprovider - IRF	0	24,931	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
200.00 Total	0	20,548	31,451	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0033		Period: From 12/01/2016 To 11/30/2017		Worksheet S-2 Part I Date/Time Prepared: 4/30/2018 2:19 pm							
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			
		V		XVIII		XIX							
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		
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)						12/01/2016	11/30/2017		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 §412.106(c)(2) (PickLe amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N	N		22.00			
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						N	N		22.01			
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N		22.02			
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N		22.03			
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.							3	N		23.00		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days				
				1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.						0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.						106	45	0	0	193		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0033	Period: From 12/01/2016 To 11/30/2017	Worksheet S-2 Part I Date/Time Prepared: 4/30/2018 2:19 pm		
		Urban/Rural	S	Date of Geogr		
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)					37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N		N		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N		N		40.00
		V	XVIII	XIX		
		1.00	2.00	3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N		N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N		N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.	N		N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N		N	N	48.00
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
		1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	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
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)					61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)					61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)					61.03

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	Y/N	IME	Direct GME	IME	Direct GME			
	1.00	2.00	3.00	4.00	5.00			
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04	
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06	
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
	1.00		2.00	3.00	4.00			
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						61.10	0.00 0.00
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						61.20	0.00 0.00
							1.00	
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>								
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)						62.00	0.00
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)						62.01	0.00
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>								
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)						63.00	N
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
			1.00	2.00	3.00			
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64.00	0.00 0.00 0.000000
		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	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
					1.00	2.00	3.00
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			Y			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N		0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			Y			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N		0	76.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0033	Period: From 12/01/2016 To 11/30/2017	Worksheet S-2 Part I Date/Time Prepared: 4/30/2018 2:19 pm		
		1.00	2.00			
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00
		1.00	2.00	3.00		
<b>Miscellaneous Cost Reporting Information</b>						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	0	0			118.01
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N				121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00
<b>Transplant Center Information</b>						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
<b>All Providers</b>						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		HB0776		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0033	Period: From 12/01/2016 To 11/30/2017	Worksheet S-2 Part I Date/Time Prepared: 4/30/2018 2:19 pm			
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: QUORUM HEALTH CORPORATION	Contractor's Name: WPS		Contractor's Number: 10101			
142.00	Street: 1573 MALLORY LANE	PO Box:					
143.00	City: BRENTWOOD	State: TN		Zip Code: 37027			
				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	
				1.00			
165.00	Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						
						0.00	
				1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.				Y	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)				0	168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)				0.25	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)			06/02/2017	08/30/2017	170.00	
				1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)				N	0	
						171.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0033		Period: From 12/01/2016 To 11/30/2017		Worksheet S-2 Part II Date/Time Prepared: 4/30/2018 2:19 pm	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	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	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	02/20/2018	Y	02/20/2018		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0033	Period: From 12/01/2016 To 11/30/2017	Worksheet S-2 Part II Date/Time Prepared: 4/30/2018 2:19 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N	N	21.00
					1.00
<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	12/31/2016
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.	COURTNEY		DALTON	41.00
42.00	Enter the employer/company name of the cost report preparer.	QUORUM HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-221-3886		COURTNEY_DALTON@QUORUMHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0033	Period: From 12/01/2016 To 11/30/2017	Worksheet S-2 Part II Date/Time Prepared: 4/30/2018 2:19 pm
		3.00		
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 14-0033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet S-3  
Part I  
Date/Time Prepared:  
4/30/2018 2:19 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	30	10,950	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)		30	10,950	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)		30	10,950	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	40	14,600		0	16.00
17.00 SUBPROVIDER - IRF	41.00	41	14,965		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
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		111				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet S-3  
Part I  
Date/Time Prepared:  
4/30/2018 2:19 pm

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)	0	0	0			1.00
2.00 HMO and other (see instructions)	0	0				2.00
3.00 HMO IPF Subprovider	360	724				3.00
4.00 HMO IRF Subprovider	165	193				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)	0	0	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)	0	0	0	0.00	51.75	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	1,156	3,919	7,146	0.00	35.16	16.00
17.00 SUBPROVIDER - IRF	1,548	407	2,396	0.00	12.75	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
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	99.66	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
33.01 LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet S-3  
Part I  
Date/Time Prepared:  
4/30/2018 2:19 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	0	0	0	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	0	0	0	0	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF	0.00	0	131	668	1,142		16.00
17.00 SUBPROVIDER - IRF	0.00	0	103	21	174		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
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00						26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days				0			33.00
33.01 LTCH site neutral days and discharges				0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet S-3  
Part II  
Date/Time Prepared:  
4/30/2018 2:19 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	6,716,136	0	6,716,136	207,299.00	32.40
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		3,185,647	0	3,185,647	99,653.00	31.97
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract Labor: Direct Patient Care		317,489	0	317,489	17,081.00	18.59
12.00	Contract labor: Top level management and other management and administrative services		56,849	0	56,849	523.00	108.70
13.00	Contract Labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		148,840	0	148,840	2,320.00	64.16
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) (see instructions)		664,885	0	664,885		
18.00	Wage-related costs (other) (see instructions)		1,026	0	1,026		
19.00	Excluded areas		620,537	0	620,537		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		
<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	109,060	0	109,060	6,145.00	17.75

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet S-3  
Part II  
Date/Time Prepared:  
4/30/2018 2:19 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)	111,854	0	111,854	422.00	265.06	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	205,420	0	205,420	7,374.00	27.86	30.00
31.00	Laundry & Linen Service	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)	0	0	0	0.00	0.00	35.00
36.00	Cafeteria	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	162,616	0	162,616	4,338.00	37.49	38.00
39.00	Central Services and Supply	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	51,478	0	51,478	918.00	56.08	40.00
41.00	Medical Records & Medical Records Library	0	0	0	0.00	0.00	41.00
42.00	Social Service	0	0	0	0.00	0.00	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet S-3  
Part III  
Date/Time Prepared:  
4/30/2018 2:19 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	6,827,990	0	6,827,990	207,721.00	32.87	1.00
2.00	Excluded area salaries (see instructions)	3,185,647	0	3,185,647	99,653.00	31.97	2.00
3.00	Subtotal salaries (line 1 minus line 2)	3,642,343	0	3,642,343	108,068.00	33.70	3.00
4.00	Subtotal other wages & related costs (see inst.)	523,178	0	523,178	19,924.00	26.26	4.00
5.00	Subtotal wage-related costs (see inst.)	665,911	0	665,911	0.00	18.28	5.00
6.00	Total (sum of lines 3 thru 5)	4,831,432	0	4,831,432	127,992.00	37.75	6.00
7.00	Total overhead cost (see instructions)	640,428	0	640,428	19,197.00	33.36	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0033	Period: From 12/01/2016 To 11/30/2017	Worksheet S-3 Part IV Date/Time Prepared: 4/30/2018 2:19 pm
				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			110,697 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)			537,946 8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)			0 8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)			0 8.02
8.03	Health Insurance (Purchased)			0 8.03
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			6,266 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			4,566 11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			190 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			23,522 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			66,942 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			405,262 17.00
18.00	Medicare Taxes - Employers Portion Only			94,779 18.00
19.00	Unemployment Insurance			0 19.00
20.00	State or Federal Unemployment Taxes			34,227 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)			1,284,397 24.00
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			1,026 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 14-0033	Period: From 12/01/2016 To 11/30/2017	Worksheet S-3 Part V Date/Time Prepared: 4/30/2018 2:19 pm
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		317,489	1,284,397
2.00	Hospital		317,489	1,284,397
3.00	Subprovider - IPF		0	0
4.00	Subprovider - IRF		0	0
5.00	Subprovider - (Other)		0	0
6.00	Swing Beds - SNF		0	0
7.00	Swing Beds - NF		0	0
8.00	Hospital-Based SNF			
9.00	Hospital-Based NF			
10.00	Hospital-Based OLTC			
11.00	Hospital-Based HHA			
12.00	Separately Certified ASC			
13.00	Hospital-Based Hospice			
14.00	Hospital-Based Health Clinic RHC			
15.00	Hospital-Based Health Clinic FQHC			
16.00	Hospital-Based-CMHC			
17.00	Renal Dialysis			
18.00	Other		0	0

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0033	Period: From 12/01/2016 To 11/30/2017	Worksheet S-10 Date/Time Prepared: 4/30/2018 2:19 pm
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				1.00		
<b>Uncompensated and indigent care cost computation</b>						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.163668	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			2,838,157	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			N	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			2,219,310	5.00	
6.00	Medicaid charges			50,819,067	6.00	
7.00	Medicaid cost (line 1 times line 6)			8,317,455	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)			3,259,988	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)						
9.00	Net revenue from stand-alone CHIP			0	9.00	
10.00	Stand-alone CHIP charges			0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00	
Other state or local government indigent care program (see instructions for each line)						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)						
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			3,259,988	19.00	
				Uninsured patients	Insured patients	Total (col. 1 + col. 2)
				1.00	2.00	3.00
Uncompensated Care (see instructions for each line)						
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	5,543,846	60,998	5,604,844	20.00	
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	907,350	50,670	958,020	21.00	
22.00	Payments received from patients for amounts previously written off as charity care	12,424	60	12,484	22.00	
23.00	Cost of charity care (line 21 minus line 22)	894,926	50,610	945,536	23.00	
				1.00		
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			Y	24.00	
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			12,349	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)			2,945,331	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			100,373	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			154,421	27.01	
28.00	Non-Medicare bad debt expense (see instructions)			2,790,910	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			510,831	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			1,456,367	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			4,716,355	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet A  
Date/Time Prepared:  
4/30/2018 2:19 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		642,908	642,908	-165,057	477,851	1.00
2.00	00200		130,518	130,518	100,192	230,710	2.00
4.00	00400		0	0	751,154	751,154	4.00
5.00	00500	109,060	7,560,398	7,669,458	-579,921	7,089,537	5.00
7.00	00700	205,420	1,457,202	1,662,622	-21,153	1,641,469	7.00
8.00	00800	0	60,682	60,682	0	60,682	8.00
9.00	00900	0	272,887	272,887	0	272,887	9.00
10.00	01000	0	1,023,555	1,023,555	0	1,023,555	10.00
13.00	01300	162,616	12,214	174,830	0	174,830	13.00
15.00	01500	51,478	298,870	350,348	-269,303	81,045	15.00
16.00	01600	0	103,911	103,911	-61	103,850	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	0	0	0	0	0	30.00
40.00	04000	2,215,327	249,404	2,464,731	-1,724	2,463,007	40.00
41.00	04100	970,320	198,081	1,168,401	-8,245	1,160,156	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	23,207	21,400	44,607	252,355	296,962	54.00
54.01	05401	24,199	20,938	45,137	-45,137	0	54.01
57.00	05700	115,861	91,437	207,298	-207,298	0	57.00
60.00	06000	870,738	336,686	1,207,424	-14,853	1,192,571	60.00
65.00	06500	0	26,535	26,535	-26,139	396	65.00
66.00	06600	353,743	46,864	400,607	231,995	632,602	66.00
67.00	06700	153,310	15,768	169,078	-169,078	0	67.00
68.00	06800	58,062	5,734	63,796	-63,796	0	68.00
73.00	07300	0	0	0	260,106	260,106	73.00
76.00	03020	505,052	118,993	624,045	-21	624,024	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	897,743	554,694	1,452,437	-16,554	1,435,883	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		6,716,136	13,249,679	19,965,815	7,462	19,973,277	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.02	19001	0	0	0	0	0	190.02
192.00	19200	0	19,648	19,648	-18,554	1,094	192.00
192.01	19201	0	0	0	11,092	11,092	192.01
194.00	07950	0	0	0	0	0	194.00
200.00		6,716,136	13,269,327	19,985,463	0	19,985,463	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet A  
Date/Time Prepared:  
4/30/2018 2:19 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-429,999	47,852	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	41,333	272,043	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	751,154	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,594,527	3,495,010	5.00
7.00	00700	OPERATION OF PLANT	225,686	1,867,155	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	60,682	8.00
9.00	00900	HOUSEKEEPING	753,038	1,025,925	9.00
10.00	01000	DIETARY	0	1,023,555	10.00
13.00	01300	NURSING ADMINISTRATION	0	174,830	13.00
15.00	01500	PHARMACY	0	81,045	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	103,850	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00
40.00	04000	SUBPROVIDER - I PF	0	2,463,007	40.00
41.00	04100	SUBPROVIDER - I RF	0	1,160,156	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	296,962	54.00
54.01	05401	ULTRA SOUND	0	0	54.01
57.00	05700	CT SCAN	0	0	57.00
60.00	06000	LABORATORY	0	1,192,571	60.00
65.00	06500	RESPIRATORY THERAPY	0	396	65.00
66.00	06600	PHYSICAL THERAPY	0	632,602	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	260,106	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0	624,024	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100	EMERGENCY	-345,785	1,090,098	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,350,254	16,623,023	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.02	19001	WORKPOWER/CORP HEALTH	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,094	192.00
192.01	19201	VI STA MEDICAL CENTER EAST	0	11,092	192.01
194.00	07950	MARKETING	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,350,254	16,635,209	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	751,154	1.00
	O		0	751,154	
<b>B - OXYGEN COST</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	20,267	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	20,267	
<b>C - RENT AND LEASE EXPENSE</b>					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	100,192	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
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
	O		0	100,192	
<b>D - OTHER CAPITAL COSTS</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	165,057	1.00
	O		0	165,057	
<b>E - DRUGS AND IV SOLUTIONS</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	239,839	1.00
	O		0	239,839	
<b>F - PT, OT, SP COSTS</b>					
1.00	PHYSICAL THERAPY	66.00	211,372	21,502	1.00
2.00		0.00	0	0	2.00
	O		211,372	21,502	
<b>G - OTHER RADIOLOGY COSTS</b>					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	140,060	112,375	1.00
2.00		0.00	0	0	2.00
	O		140,060	112,375	
<b>H - MOB COSTS</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	7,462	1.00
2.00	VISTA MEDICAL CENTER EAST	192.01	0	11,092	2.00
	O		0	18,554	
500.00	Grand Total: Increases		351,432	1,428,940	500.00

RECLASSIFICATIONS

Provider CCN: 14-0033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet A-6

Date/Time Prepared:  
4/30/2018 2:19 pm

		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	751,154	0		1.00
	O		0	751,154			
<b>B - OXYGEN COST</b>							
1.00	OPERATION OF PLANT	7.00	0	796	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	19,471	0		2.00
	TOTALS		0	20,267			
<b>C - RENT AND LEASE EXPENSE</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,286	10		1.00
2.00	OPERATION OF PLANT	7.00	0	20,357	0		2.00
3.00	PHARMACY	15.00	0	29,464	0		3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	61	0		4.00
5.00	SUBPROVIDER - IPF	40.00	0	1,724	0		5.00
6.00	SUBPROVIDER - IRF	41.00	0	8,245	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	80	0		7.00
8.00	LABORATORY	60.00	0	14,853	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	6,668	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	777	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	102	0		11.00
12.00	MENTAL HEALTH ANCILLARY	76.00	0	21	0		12.00
13.00	EMERGENCY	91.00	0	16,492	0		13.00
14.00	EMERGENCY	91.00	0	62	0		14.00
	O		0	100,192			
<b>D - OTHER CAPITAL COSTS</b>							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	165,057	13		1.00
	O		0	165,057			
<b>E - DRUGS AND IV SOLUTIONS</b>							
1.00	PHARMACY	15.00	0	239,839	0		1.00
	O		0	239,839			
<b>F - PT, OT, SP COSTS</b>							
1.00	OCCUPATIONAL THERAPY	67.00	153,310	15,768	0		1.00
2.00	SPEECH PATHOLOGY	68.00	58,062	5,734	0		2.00
	O		211,372	21,502			
<b>G - OTHER RADIOLOGY COSTS</b>							
1.00	ULTRA SOUND	54.01	24,199	20,938	0		1.00
2.00	CT SCAN	57.00	115,861	91,437	0		2.00
	O		140,060	112,375			
<b>H - MOB COSTS</b>							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	18,554	0		1.00
2.00		0.00	0	0	0		2.00
	O		0	18,554			
500.00	Grand Total : Decreases		351,432	1,428,940			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet A-7  
Part I  
Date/Time Prepared:  
4/30/2018 2:19 pm

	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	29,979,490	181,970	0	181,970	3.00
4.00	Building Improvements	2,965,435	4,875	0	4,875	4.00
5.00	Fixed Equipment	4,464,039	0	0	0	5.00
6.00	Movable Equipment	22,548,589	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	62,462,834	186,845	0	186,845	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	62,462,834	186,845	0	186,845	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	30,161,460	0			3.00
4.00	Building Improvements	2,970,310	0			4.00
5.00	Fixed Equipment	4,464,039	0			5.00
6.00	Movable Equipment	22,548,589	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	62,649,679	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	62,649,679	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet A-7  
Part II  
Date/Time Prepared:  
4/30/2018 2:19 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	642,908	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	130,518	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	773,426	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	642,908				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	130,518				2.00
3.00	Total (sum of lines 1-2)	0	773,426				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet A-7  
Part III  
Date/Time Prepared:  
4/30/2018 2:19 pm

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	35,637,050	0	35,637,050	0.568831	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	27,012,629	0	27,012,629	0.431169	0	2.00
3.00	Total (sum of lines 1-2)	62,649,679	0	62,649,679	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	212,909	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	171,851	100,192	2.00
3.00	Total (sum of lines 1-2)	0	0	0	384,760	100,192	3.00
Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	-165,057	0	47,852	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	272,043	2.00
3.00	Total (sum of lines 1-2)	0	0	-165,057	0	319,895	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet A-8

Date/Time Prepared:  
4/30/2018 2:19 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-2,408		ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	9	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-1,159,091				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	79,796				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	B		0	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00 Sale of medical records and abstracts	B		0	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)	B		0	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	-462,581		CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	A	29,677		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	-25,510		CAP REL COSTS-BLDG & FIXT	1.00	9	33.00

Provider CCN: 14-0033  
 Period: From 12/01/2016 To 11/30/2017  
 Worksheet A-8  
 Date/Time Prepared: 4/30/2018 2:19 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
33.01 LOBBYING EXPENSE	A	-3,532	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02 FITNESS REVENUE	B	-165	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03 MSHIPS/PROF DUES/SUB	A	-66,008	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04 LEGAL FEES	A	-39,319	ADMINISTRATIVE & GENERAL	5.00	0	33.04
35.00 TRAINING REVENUE	B	0	NURSING ADMINISTRATION	13.00	0	35.00
36.00 PHONE & TV DEPRECIATION	A	-2,696	CAP REL COSTS-MVBLE EQUIP	2.00	9	36.00
36.01 TV CABLE EXPENSE	A	-7,631	ADMINISTRATIVE & GENERAL	5.00	0	36.01
37.00 STATE OPERATING TAX	A	-2,685,294	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00 MISC REVENUE	B	-7,941	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00 ALLOCATED SECURITY / PLANT OPS	A	225,686	OPERATION OF PLANT	7.00	0	39.00
40.00 ALLOCATED HOUSEKEEPING	A	753,038	HOUSEKEEPING	9.00	0	40.00
44.00 ALLOCATED EKG	A	23,725	EMERGENCY	91.00	0	44.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,350,254				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: 14-0033	Period: From 12/01/2016 To 11/30/2017	Worksheet A-8-1 Date/Time Prepared: 4/30/2018 2:19 pm
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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	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>					
1.00	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	556,593 1.00
2.00	0.00			0	0 2.00
3.00	0.00			0	0 3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	58,092	0 4.00
4.01	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	14,352	0 4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL HOME OFFICE COST	109,680	0 4.02
4.03	0.00			0	0 4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	ALLOCATION FROM VISTA EAST	105,917	0 4.04
4.05	0.00			0	0 4.05
4.06	0.00			0	0 4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	QHC SPECIFIC COSTS	348,348	0 4.07
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			636,389	556,593 5.00

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

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00
<b>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	B	CHS	100.00	QUORUM HEALTH C	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: 14-0033	Period: From 12/01/2016 To 11/30/2017	Worksheet A-8-1 Date/Time Prepared: 4/30/2018 2:19 pm
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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	-556,593	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	58,092	9		4.00
4.01	14,352	9		4.01
4.02	109,680	0		4.02
4.03	0	0		4.03
4.04	105,917	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	348,348	0		4.07
5.00	79,796			5.00

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

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

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

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

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the requested 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: 14-0033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet A-8-2

Date/Time Prepared:  
4/30/2018 2:19 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	789,581	789,581	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	91.00	EMERGENCY	369,510	369,510	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			1,159,091	1,159,091	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	91.00	EMERGENCY	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	789,581	1.00
2.00	40.00	SUBPROVIDER - IPF	0	0	0	0	2.00
3.00	41.00	SUBPROVIDER - IRF	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	369,510	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	1,159,091	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet B  
Part I  
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	47,852	47,852			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	272,043		272,043		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	751,154	0	0	751,154	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	3,495,010	1,786	10,152	12,198	5.00
7.00 00700	OPERATION OF PLANT	1,867,155	28,518	162,133	22,975	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	60,682	620	3,524	0	8.00
9.00 00900	HOUSEKEEPING	1,025,925	1,396	7,934	0	9.00
10.00 01000	DIETARY	1,023,555	371	2,110	0	10.00
13.00 01300	NURSING ADMINISTRATION	174,830	0	0	18,187	13.00
15.00 01500	PHARMACY	81,045	765	4,347	5,757	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	103,850	327	1,857	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
40.00 04000	SUBPROVIDER - I/PF	2,463,007	4,316	24,538	247,771	40.00
41.00 04100	SUBPROVIDER - IRF	1,160,156	2,371	13,477	108,523	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00 05400	RADIOLOGY-DIAGNOSTIC	296,962	0	0	18,260	54.00
54.01 05401	ULTRA SOUND	0	0	0	0	54.01
57.00 05700	CT SCAN	0	0	0	0	57.00
60.00 06000	LABORATORY	1,192,571	12	70	97,386	60.00
65.00 06500	RESPIRATORY THERAPY	396	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	632,602	1,107	6,294	63,204	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
73.00 07300	DRUGS CHARGED TO PATIENTS	260,106	0	0	0	73.00
76.00 03020	MENTAL HEALTH ANCILLARY	624,024	1,044	5,934	56,487	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100	EMERGENCY	1,090,098	3,225	18,337	100,406	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	16,623,023	45,858	260,707	751,154	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.02 19001	WORKPOWER/CORP HEALTH	0	1,994	11,336	0	190.02
192.00 19200	PHYSICIANS' PRIVATE OFFICES	1,094	0	0	0	192.00
192.01 19201	VI STA MEDICAL CENTER EAST	11,092	0	0	0	192.01
194.00 07950	MARKETING	0	0	0	0	194.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	16,635,209	47,852	272,043	751,154	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet B  
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
<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	3,519,146				5.00
7.00	00700	OPERATION OF PLANT	558,290	2,639,071			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,393	93,227	175,446		8.00
9.00	00900	HOUSEKEEPING	277,767	209,897	0	1,522,919	9.00
10.00	01000	DIETARY	275,294	55,828	0	36,397	1,393,555
13.00	01300	NURSING ADMINISTRATION	51,788	0	0	0	13.00
15.00	01500	PHARMACY	24,661	115,009	0	74,980	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	28,450	49,121	0	32,024	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
40.00	04000	SUBPROVIDER - I PF	735,065	649,140	68,722	423,206	1,011,647
41.00	04100	SUBPROVIDER - I RF	344,649	356,524	37,743	232,436	381,908
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	RADIOLOGY-DIAGNOSTIC	84,577	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
60.00	06000	LABORATORY	346,128	1,852	0	1,208	60.00
65.00	06500	RESPIRATORY THERAPY	106	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	188,676	166,493	17,625	108,545	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	69,789	0	0	0	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	184,459	156,975	0	102,340	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	EMERGENCY	325,207	485,107	51,356	316,265	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,512,299	2,339,173	175,446	1,327,401	1,393,555
<b>NONREIMBURSABLE COST CENTERS</b>							
190.02	19001	WORKPOWER/CORP HEALTH	3,577	299,898	0	195,518	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	294	0	0	0	192.00
192.01	19201	VI STA MEDICAL CENTER EAST	2,976	0	0	0	192.01
194.00	07950	MARKETING	0	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,519,146	2,639,071	175,446	1,522,919	1,393,555

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0033

Period:  
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Cost Center Description		NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	15.00	16.00	24.00	25.00	
<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
13.00	01300	244,805					13.00
15.00	01500	0	306,564				15.00
16.00	01600	0	0	215,629			16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	0	0	0	0	0	30.00
40.00	04000	170,240	0	56,135	5,853,787	0	40.00
41.00	04100	74,565	0	14,152	2,726,504	0	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	0	0	28,165	427,964	0	54.00
54.01	05401	0	0	0	0	0	54.01
57.00	05700	0	0	0	0	0	57.00
60.00	06000	0	0	20,287	1,659,514	0	60.00
65.00	06500	0	0	340	842	0	65.00
66.00	06600	0	0	12,224	1,196,770	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
73.00	07300	0	306,564	14,206	650,665	0	73.00
76.00	03020	0	0	9,865	1,141,128	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	0	0	60,255	2,450,256	0	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		244,805	306,564	215,629	16,107,430	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.02	19001	0	0	0	512,323	0	190.02
192.00	19200	0	0	0	1,388	0	192.00
192.01	19201	0	0	0	14,068	0	192.01
194.00	07950	0	0	0	0	0	194.00
200.00					0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		244,805	306,564	215,629	16,635,209	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0033

Period:  
From 12/01/2016  
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Cost Center Description		Total	
		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
13.00	01300	NURSING ADMINISTRATION	13.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
40.00	04000	SUBPROVIDER - IPF	40.00
41.00	04100	SUBPROVIDER - IRF	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	ULTRA SOUND	54.01
57.00	05700	CT SCAN	57.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
91.00	09100	EMERGENCY	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.02	19001	WORKPOWER/CORP HEALTH	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	VI STA MEDICAL CENTER EAST	192.01
194.00	07950	MARKETING	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet B  
Part II  
Date/Time Prepared:  
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<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	1,786	10,152	11,938	5.00
7.00 00700	OPERATION OF PLANT	0	28,518	162,133	190,651	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	620	3,524	4,144	8.00
9.00 00900	HOUSEKEEPING	0	1,396	7,934	9,330	9.00
10.00 01000	DIETARY	0	371	2,110	2,481	10.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	13.00
15.00 01500	PHARMACY	0	765	4,347	5,112	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	327	1,857	2,184	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
40.00 04000	SUBPROVIDER - IPF	0	4,316	24,538	28,854	40.00
41.00 04100	SUBPROVIDER - IRF	0	2,371	13,477	15,848	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
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
60.00 06000	LABORATORY	0	12	70	82	60.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	1,107	6,294	7,401	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03020	MENTAL HEALTH ANCILLARY	0	1,044	5,934	6,978	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100	EMERGENCY	0	3,225	18,337	21,562	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	45,858	260,707	306,565	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.02 19001	WORKPOWER/CORP HEALTH	0	1,994	11,336	13,330	190.02
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01 19201	VISTA MEDICAL CENTER EAST	0	0	0	0	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 through 201)	0	47,852	272,043	319,895	202.00



ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet B  
Part II  
Date/Time Prepared:  
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Cost Center Description		NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	15.00	16.00	24.00	25.00	
<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
13.00	01300	176					13.00
15.00	01500	0	14,847				15.00
16.00	01600	0	0	6,402			16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	0	0	0	0	0	30.00
40.00	04000	123	0	1,665	97,798	0	40.00
41.00	04100	53	0	420	51,994	0	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	0	0	836	1,123	0	54.00
54.01	05401	0	0	0	0	0	54.01
57.00	05700	0	0	0	0	0	57.00
60.00	06000	0	0	602	2,013	0	60.00
65.00	06500	0	0	10	10	0	65.00
66.00	06600	0	0	363	23,481	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
73.00	07300	0	14,847	421	15,505	0	73.00
76.00	03020	0	0	293	21,069	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	0	0	1,792	68,384	0	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00							
		176	14,847	6,402	281,377	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.02	19001	0	0	0	38,507	0	190.02
192.00	19200	0	0	0	1	0	192.00
192.01	19201	0	0	0	10	0	192.01
194.00	07950	0	0	0	0	0	194.00
200.00					0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		176	14,847	6,402	319,895	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet B  
Part II  
Date/Time Prepared:  
4/30/2018 2:19 pm

Cost Center Description		Total	
		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
13.00	01300	NURSING ADMINISTRATION	13.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
40.00	04000	SUBPROVIDER - IPF	40.00
41.00	04100	SUBPROVIDER - IRF	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	ULTRA SOUND	54.01
57.00	05700	CT SCAN	57.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
91.00	09100	EMERGENCY	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.02	19001	WORKPOWER/CORP HEALTH	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	VISTA MEDICAL CENTER EAST	192.01
194.00	07950	MARKETING	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet B-1  
Date/Time Prepared:  
4/30/2018 2:19 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	225,337				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		225,337			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	6,716,136		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	8,409	8,409	109,060	-3,519,146	5.00
7.00 00700	OPERATION OF PLANT	134,297	134,297	205,420	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	2,919	2,919	0	0	8.00
9.00 00900	HOUSEKEEPING	6,572	6,572	0	0	9.00
10.00 01000	DIETARY	1,748	1,748	0	0	10.00
13.00 01300	NURSING ADMINISTRATION	0	0	162,616	0	13.00
15.00 01500	PHARMACY	3,601	3,601	51,478	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,538	1,538	0	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
40.00 04000	SUBPROVIDER - I/PF	20,325	20,325	2,215,327	0	40.00
41.00 04100	SUBPROVIDER - IRF	11,163	11,163	970,320	0	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	163,267	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
60.00 06000	LABORATORY	58	58	870,738	0	60.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	5,213	5,213	565,115	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
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03020	MENTAL HEALTH ANCILLARY	4,915	4,915	505,052	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100	EMERGENCY	15,189	15,189	897,743	0	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	215,947	215,947	6,716,136	-3,519,146	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.02 19001	WORKPOWER/CORP HEALTH	9,390	9,390	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	0	0	0	192.01
194.00 07950	MARKETING	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)	47,852	272,043	751,154	3,519,146	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.212357	1.207272	0.111843	0.268308	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0	11,938	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000	0.000910	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet B-1

Date/Time Prepared:  
4/30/2018 2:19 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRS G HR)		
		7.00	8.00	9.00	10.00	13.00		
<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	82,631				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	2,919	161,198			8.00	
9.00	00900	HOUSEKEEPING	6,572	0	73,140		9.00	
10.00	01000	DIETARY	1,748	0	1,748	36,960	10.00	
13.00	01300	NURSING ADMINISTRATION	0	0	0	3,185,647	13.00	
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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00	
40.00	04000	SUBPROVIDER - I PF	20,325	63,141	20,325	26,831	2,215,327	40.00
41.00	04100	SUBPROVIDER - IRF	11,163	34,678	11,163	10,129	970,320	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
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
60.00	06000	LABORATORY	58	0	58	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,213	16,194	5,213	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
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	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100	EMERGENCY	15,189	47,185	15,189	0	0	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	73,241	161,198	63,750	36,960	3,185,647	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.02	19001	WORKPOWER/CORP HEALTH	9,390	0	9,390	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	0	0	0	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)	2,639,071	175,446	1,522,919	1,393,555	244,805	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	31.938026	1.088388	20.821972	37.704410	0.076846	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	192,545	11,005	25,586	8,099	176	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.330179	0.068270	0.349822	0.219129	0.000055	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet B-1

Date/Time Prepared:  
4/30/2018 2:19 pm

Cost Center Description		PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		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
13.00	01300			13.00
15.00	01500	239,839		15.00
16.00	01600	0	98,415,303	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	0	0	30.00
40.00	04000	0	25,620,809	40.00
41.00	04100	0	6,459,328	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
54.00	05400	0	12,854,964	54.00
54.01	05401	0	0	54.01
57.00	05700	0	0	57.00
60.00	06000	0	9,259,202	60.00
65.00	06500	0	155,354	65.00
66.00	06600	0	5,579,227	66.00
67.00	06700	0	0	67.00
68.00	06800	0	0	68.00
73.00	07300	239,839	6,483,880	73.00
76.00	03020	0	4,502,287	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00	09100	0	27,500,252	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
118.00		239,839	98,415,303	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.02	19001	0	0	190.02
192.00	19200	0	0	192.00
192.01	19201	0	0	192.01
194.00	07950	0	0	194.00
200.00				200.00
201.00				201.00
202.00		306,564	215,629	202.00
203.00		1.278207	0.002191	203.00
204.00		14,847	6,402	204.00
205.00		0.061904	0.000065	205.00
206.00				206.00
207.00				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet C  
Part I  
Date/Time Prepared:  
4/30/2018 2:19 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE		Total Costs
					Disallowance		
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	0		0	0	0	
40.00	04000 SUBPROVIDER - IPF	5,853,787		5,853,787	0	5,853,787	
41.00	04100 SUBPROVIDER - IRF	2,726,504		2,726,504	0	2,726,504	
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400 RADIOLOGY-DIAGNOSTIC	427,964		427,964	0	427,964	
54.01	05401 ULTRA SOUND	0		0	0	0	
57.00	05700 CT SCAN	0		0	0	0	
60.00	06000 LABORATORY	1,659,514		1,659,514	0	1,659,514	
65.00	06500 RESPIRATORY THERAPY	842	0	842	0	842	
66.00	06600 PHYSICAL THERAPY	1,196,770	0	1,196,770	0	1,196,770	
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	650,665		650,665	0	650,665	
76.00	03020 MENTAL HEALTH ANCILLARY	1,141,128		1,141,128	0	1,141,128	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100 EMERGENCY	2,450,256		2,450,256	0	2,450,256	
200.00	Subtotal (see instructions)	16,107,430	0	16,107,430	0	16,107,430	
201.00	Less Observation Beds	0		0	0	0	
202.00	Total (see instructions)	16,107,430	0	16,107,430	0	16,107,430	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet C  
Part I  
Date/Time Prepared:  
4/30/2018 2:19 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0		0		30.00
40.00	04000	SUBPROVIDER - I/PF	25,620,809		25,620,809		40.00
41.00	04100	SUBPROVIDER - IRF	6,459,328		6,459,328		41.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	356,459	12,498,505	12,854,964	0.033292	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
60.00	06000	LABORATORY	1,405,824	7,853,378	9,259,202	0.179229	60.00
65.00	06500	RESPIRATORY THERAPY	2,131	153,223	155,354	0.005420	65.00
66.00	06600	PHYSICAL THERAPY	5,579,227	0	5,579,227	0.214505	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
73.00	07300	DRUGS CHARGED TO PATIENTS	4,306,088	2,177,792	6,483,880	0.100351	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	427,106	4,075,181	4,502,287	0.253455	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	2,534,969	24,965,283	27,500,252	0.089099	91.00
200.00		Subtotal (see instructions)	46,691,941	51,723,362	98,415,303		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	46,691,941	51,723,362	98,415,303		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet C  
Part I  
Date/Time Prepared:  
4/30/2018 2:19 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		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 - IRF				41.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.033292			54.00
54.01	05401 ULTRA SOUND	0.000000			54.01
57.00	05700 CT SCAN	0.000000			57.00
60.00	06000 LABORATORY	0.179229			60.00
65.00	06500 RESPIRATORY THERAPY	0.005420			65.00
66.00	06600 PHYSICAL THERAPY	0.214505			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.100351			73.00
76.00	03020 MENTAL HEALTH ANCILLARY	0.253455			76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100 EMERGENCY	0.089099			91.00
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: 14-0033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet C  
Part I  
Date/Time Prepared:  
4/30/2018 2:19 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX		Hospital		PPS
				Total Costs	RCE Disallowance	Total Costs		
								Costs
		1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000 ADULTS & PEDIATRICS	0		0	0	0	0	30.00
40.00	04000 SUBPROVIDER - IPF	5,853,787		5,853,787	0	5,853,787	0	40.00
41.00	04100 SUBPROVIDER - IRF	2,726,504		2,726,504	0	2,726,504	0	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
54.00	05400 RADIOLOGY-DIAGNOSTIC	427,964		427,964	0	427,964	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
60.00	06000 LABORATORY	1,659,514		1,659,514	0	1,659,514	0	60.00
65.00	06500 RESPIRATORY THERAPY	842	0	842	0	842	0	65.00
66.00	06600 PHYSICAL THERAPY	1,196,770	0	1,196,770	0	1,196,770	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
73.00	07300 DRUGS CHARGED TO PATIENTS	650,665		650,665	0	650,665	0	73.00
76.00	03020 MENTAL HEALTH ANCILLARY	1,141,128		1,141,128	0	1,141,128	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100 EMERGENCY	2,450,256		2,450,256	0	2,450,256	0	91.00
200.00	Subtotal (see instructions)	16,107,430	0	16,107,430	0	16,107,430	0	200.00
201.00	Less Observation Beds	0		0	0	0	0	201.00
202.00	Total (see instructions)	16,107,430	0	16,107,430	0	16,107,430	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet C  
Part I  
Date/Time Prepared:  
4/30/2018 2:19 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XIX Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0		0		30.00
40.00	04000	SUBPROVIDER - I/PF	25,620,809		25,620,809		40.00
41.00	04100	SUBPROVIDER - IRF	6,459,328		6,459,328		41.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	356,459	12,498,505	12,854,964	0.033292	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
60.00	06000	LABORATORY	1,405,824	7,853,378	9,259,202	0.179229	60.00
65.00	06500	RESPIRATORY THERAPY	2,131	153,223	155,354	0.005420	65.00
66.00	06600	PHYSICAL THERAPY	5,579,227	0	5,579,227	0.214505	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
73.00	07300	DRUGS CHARGED TO PATIENTS	4,306,088	2,177,792	6,483,880	0.100351	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	427,106	4,075,181	4,502,287	0.253455	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	2,534,969	24,965,283	27,500,252	0.089099	91.00
200.00		Subtotal (see instructions)	46,691,941	51,723,362	98,415,303		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	46,691,941	51,723,362	98,415,303		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet C  
Part I  
Date/Time Prepared:  
4/30/2018 2:19 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	PPS
		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 - IRF				41.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.033292			54.00
54.01	05401 ULTRA SOUND	0.000000			54.01
57.00	05700 CT SCAN	0.000000			57.00
60.00	06000 LABORATORY	0.179229			60.00
65.00	06500 RESPIRATORY THERAPY	0.005420			65.00
66.00	06600 PHYSICAL THERAPY	0.214505			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.100351			73.00
76.00	03020 MENTAL HEALTH ANCILLARY	0.253455			76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100 EMERGENCY	0.089099			91.00
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: 14-0033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet C  
Part II  
Date/Time Prepared:  
4/30/2018 2:19 pm

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>								
54.00	05400	RADIOLOGY-DIAGNOSTIC	427,964	1,123	426,841	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
60.00	06000	LABORATORY	1,659,514	2,013	1,657,501	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	842	10	832	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,196,770	23,481	1,173,289	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
73.00	07300	DRUGS CHARGED TO PATIENTS	650,665	15,505	635,160	0	0	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	1,141,128	21,069	1,120,059	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100	EMERGENCY	2,450,256	68,384	2,381,872	0	0	91.00
200.00		Subtotal (sum of lines 50 thru 199)	7,527,139	131,585	7,395,554	0	0	200.00
201.00		Less Observation Beds	0	0	0	0	0	201.00
202.00		Total (line 200 minus line 201)	7,527,139	131,585	7,395,554	0	0	202.00

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

Provider CCN: 14-0033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet C  
Part II  
Date/Time Prepared:  
4/30/2018 2:19 pm

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		
Title XIX						
		Hospital		PPS		
ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	427,964	12,854,964	0.033292	54.00
54.01	05401	ULTRA SOUND	0	0	0.000000	54.01
57.00	05700	CT SCAN	0	0	0.000000	57.00
60.00	06000	LABORATORY	1,659,514	9,259,202	0.179229	60.00
65.00	06500	RESPIRATORY THERAPY	842	155,354	0.005420	65.00
66.00	06600	PHYSICAL THERAPY	1,196,770	5,579,227	0.214505	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	650,665	6,483,880	0.100351	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	1,141,128	4,502,287	0.253455	76.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,450,256	27,500,252	0.089099	91.00
200.00		Subtotal (sum of lines 50 thru 199)	7,527,139	66,335,166		200.00
201.00		Less Observation Beds	0	0		201.00
202.00		Total (line 200 minus line 201)	7,527,139	66,335,166		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-0033		Period: From 12/01/2016 To 11/30/2017		Worksheet D Part I Date/Time Prepared: 4/30/2018 2:19 pm	
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	0	0	0	0	0.00	30.00
40.00	SUBPROVIDER - IPF	97,798	0	97,798	7,146	13.69	40.00
41.00	SUBPROVIDER - IRF	51,994	0	51,994	2,396	21.70	41.00
200.00	Total (Lines 30 through 199)	149,792		149,792	9,542		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	0	0				
40.00	SUBPROVIDER - IPF	1,156	15,826				
41.00	SUBPROVIDER - IRF	1,548	33,592				
200.00	Total (Lines 30 through 199)	2,704	49,418				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 14-0033	Period: From 12/01/2016 To 11/30/2017	Worksheet D Part II Date/Time Prepared: 4/30/2018 2:19 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital PPS							
ANCILLARY SERVICE COST CENTERS							
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,123	12,854,964	0.000087	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
60.00	06000 LABORATORY	2,013	9,259,202	0.000217	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	10	155,354	0.000064	0	0	65.00
66.00	06600 PHYSICAL THERAPY	23,481	5,579,227	0.004209	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
73.00	07300 DRUGS CHARGED TO PATIENTS	15,505	6,483,880	0.002391	0	0	73.00
76.00	03020 MENTAL HEALTH ANCILLARY	21,069	4,502,287	0.004680	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	68,384	27,500,252	0.002487	0	0	91.00
200.00	Total (lines 50 through 199)	131,585	66,335,166		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0033	Period: From 12/01/2016 To 11/30/2017	Worksheet D Part III Date/Time Prepared: 4/30/2018 2:19 pm
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Cost Center Description		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
		1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00	
200.00		Total (lines 30 through 199)	0	0	0	0	200.00	
Cost Center Description		Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days		
		4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0.00	0	30.00	
40.00	04000	SUBPROVIDER - IPF	0	0	7,146	1,156	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	2,396	1,548	41.00	
200.00		Total (lines 30 through 199)	0	0	9,542	2,704	200.00	
Cost Center Description		Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
		9.00						
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0					30.00
40.00	04000	SUBPROVIDER - IPF	0					40.00
41.00	04100	SUBPROVIDER - IRF	0					41.00
200.00		Total (lines 30 through 199)	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 14-0033		Period: From 12/01/2016 To 11/30/2017		Worksheet D Part IV Date/Time Prepared: 4/30/2018 2:19 pm	
Cost Center Description		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	PPS
		1.00	2A	2.00	3A	3.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
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
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
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>							
91.00	09100	EMERGENCY	0	0	0	0	91.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0033	Period: From 12/01/2016 To 11/30/2017	Worksheet D Part IV Date/Time Prepared: 4/30/2018 2:19 pm
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Cost Center Description	Title XVIII		Hospital		PPS			
	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)			
	4.00	5.00	6.00	7.00	8.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,854,964	0.000000	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
60.00	06000	LABORATORY	0	0	0	9,259,202	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	155,354	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,579,227	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,483,880	0.000000	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0	0	0	4,502,287	0.000000	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100	EMERGENCY	0	0	0	27,500,252	0.000000	91.00
200.00		Total (lines 50 through 199)	0	0	0	66,335,166		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet D  
Part IV  
Date/Time Prepared:  
4/30/2018 2:19 pm

Cost Center Description		Title XVIII			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	886,133	0 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
60.00	06000	LABORATORY	0.000000	0	0	442,817	0 60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	6,747	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0 68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	158,157	0 73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0.000000	0	0	326,926	0 76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	EMERGENCY	0.000000	0	0	1,977,900	0 91.00
200.00		Total (lines 50 through 199)		0	0	3,798,680	0 200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0033	Period: From 12/01/2016 To 11/30/2017	Worksheet D Part V Date/Time Prepared: 4/30/2018 2:19 pm				
		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>								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.033292	886,133	0	0	29,501	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
60.00	06000	LABORATORY	0.179229	442,817	0	0	79,366	60.00
65.00	06500	RESPIRATORY THERAPY	0.005420	6,747	0	0	37	65.00
66.00	06600	PHYSICAL THERAPY	0.214505	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
73.00	07300	DRUGS CHARGED TO PATIENTS	0.100351	158,157	0	0	15,871	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0.253455	326,926	0	0	82,861	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100	EMERGENCY	0.089099	1,977,900	0	0	176,229	91.00
200.00		Subtotal (see instructions)		3,798,680	0	0	383,865	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		3,798,680	0	0	383,865	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0033		Period: From 12/01/2016 To 11/30/2017		Worksheet D Part V Date/Time Prepared: 4/30/2018 2:19 pm	
				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.)			
ANCI LLARY SERVICE COST CENTERS							
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
60.00	06000	LABORATORY	0	0			60.00
65.00	06500	RESPIRATORY THERAPY	0	0			65.00
66.00	06600	PHYSICAL THERAPY	0	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	0			68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0			73.00
76.00	03020	MENTAL HEALTH ANCI LLARY	0	0			76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0			91.00
200.00		Subtotal (see instructions)	0	0			200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0				201.00
202.00		Net Charges (line 200 - line 201)	0	0			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0033 Component CCN: 14-S033		Period: From 12/01/2016 To 11/30/2017		Worksheet D Part II Date/Time Prepared: 4/30/2018 2:19 pm		
				Title XVIII		Subprovider - IPF	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,123	12,854,964	0.000087	28,203	2	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
60.00	06000	LABORATORY	2,013	9,259,202	0.000217	266,855	58	60.00
65.00	06500	RESPIRATORY THERAPY	10	155,354	0.000064	0	0	65.00
66.00	06600	PHYSICAL THERAPY	23,481	5,579,227	0.004209	720	3	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
73.00	07300	DRUGS CHARGED TO PATIENTS	15,505	6,483,880	0.002391	618,264	1,478	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	21,069	4,502,287	0.004680	59,143	277	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	68,384	27,500,252	0.002487	352,555	877	91.00
200.00		Total (lines 50 through 199)	131,585	66,335,166		1,325,740	2,695	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0033 Component CCN: 14-S033	Period: From 12/01/2016 To 11/30/2017	Worksheet D Part IV Date/Time Prepared: 4/30/2018 2:19 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00	3A	3.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
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
60.00 06000 LABORATORY	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
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>						
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
200.00 Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 14-0033 Component CCN: 14-S033		Period: From 12/01/2016 To 11/30/2017		Worksheet D Part IV Date/Time Prepared: 4/30/2018 2:19 pm		
				Title XVIII		Subprovider - IPF	PPS	
Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,854,964	0.000000	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
60.00	06000	LABORATORY	0	0	0	9,259,202	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	155,354	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,579,227	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,483,880	0.000000	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0	0	0	4,502,287	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	27,500,252	0.000000	91.00
200.00		Total (lines 50 through 199)	0	0	0	66,335,166		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 14-0033 Component CCN: 14-S033		Period: From 12/01/2016 To 11/30/2017		Worksheet D Part IV Date/Time Prepared: 4/30/2018 2:19 pm	
				Title XVIII		Subprovider - IPF	PPS
Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	28,203	0	0	54.00
54.01	05401	ULTRA SOUND	0.000000	0	0	0	54.01
57.00	05700	CT SCAN	0.000000	0	0	0	57.00
60.00	06000	LABORATORY	0.000000	266,855	0	1,386	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	720	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	618,264	0	429	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0.000000	59,143	0	133,078	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.000000	352,555	0	16,163	91.00
200.00		Total (lines 50 through 199)		1,325,740	0	151,056	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0033 Component CCN: 14-S033	Period: From 12/01/2016 To 11/30/2017	Worksheet D Part V Date/Time Prepared: 4/30/2018 2:19 pm
	Title XVIII	Subprovider - IPF	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>						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0.033292	0	0	0	54.00
54.01 05401	ULTRA SOUND	0.000000	0	0	0	54.01
57.00 05700	CT SCAN	0.000000	0	0	0	57.00
60.00 06000	LABORATORY	0.179229	1,386	0	0	248 60.00
65.00 06500	RESPIRATORY THERAPY	0.005420	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0.214505	0	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0.000000	0	0	0	68.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0.100351	429	0	0	43 73.00
76.00 03020	MENTAL HEALTH ANCILLARY	0.253455	133,078	0	0	33,729 76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100	EMERGENCY	0.089099	16,163	0	0	1,440 91.00
200.00	Subtotal (see instructions)		151,056	0	0	35,460 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 - line 201)		151,056	0	0	35,460 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0033 Component CCN: 14-S033	Period: From 12/01/2016 To 11/30/2017	Worksheet D Part V Date/Time Prepared: 4/30/2018 2:19 pm
	Title XVIII	Subprovider - IPF	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>				
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
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
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>				
91.00	09100 EMERGENCY	0	0	91.00
200.00	Subtotal (see instructions)	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0033 Component CCN: 14-T033		Period: From 12/01/2016 To 11/30/2017		Worksheet D Part II Date/Time Prepared: 4/30/2018 2:19 pm		
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		
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,123	12,854,964	0.000087	94,866	8	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
60.00	06000	LABORATORY	2,013	9,259,202	0.000217	318,605	69	60.00
65.00	06500	RESPIRATORY THERAPY	10	155,354	0.000064	0	0	65.00
66.00	06600	PHYSICAL THERAPY	23,481	5,579,227	0.004209	3,531,156	14,863	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
73.00	07300	DRUGS CHARGED TO PATIENTS	15,505	6,483,880	0.002391	1,078,980	2,580	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	21,069	4,502,287	0.004680	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	68,384	27,500,252	0.002487	128,858	320	91.00
200.00		Total (lines 50 through 199)	131,585	66,335,166		5,152,465	17,840	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0033 Component CCN: 14-T033	Period: From 12/01/2016 To 11/30/2017	Worksheet D Part IV Date/Time Prepared: 4/30/2018 2:19 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00	3A	3.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
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
60.00 06000 LABORATORY	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
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>						
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
200.00 Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 14-0033 Component CCN: 14-T033		Period: From 12/01/2016 To 11/30/2017		Worksheet D Part IV Date/Time Prepared: 4/30/2018 2:19 pm		
				Title XVIII		Subprovider - IRF	PPS	
Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,854,964	0.000000	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
60.00	06000	LABORATORY	0	0	0	9,259,202	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	155,354	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,579,227	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,483,880	0.000000	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0	0	0	4,502,287	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	27,500,252	0.000000	91.00
200.00		Total (lines 50 through 199)	0	0	0	66,335,166		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 14-0033 Component CCN: 14-T033		Period: From 12/01/2016 To 11/30/2017		Worksheet D Part IV Date/Time Prepared: 4/30/2018 2:19 pm	
				Title XVIII		Subprovider - IRF	
Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	94,866	0	0	54.00
54.01	05401	ULTRA SOUND	0.000000	0	0	0	54.01
57.00	05700	CT SCAN	0.000000	0	0	0	57.00
60.00	06000	LABORATORY	0.000000	318,605	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	3,531,156	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,078,980	0	0	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0.000000	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.000000	128,858	0	0	91.00
200.00		Total (lines 50 through 199)		5,152,465	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-0033		Period: From 12/01/2016 To 11/30/2017		Worksheet D Part I Date/Time Prepared: 4/30/2018 2:19 pm	
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	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	0	0	0	0	0.00	
40.00	SUBPROVIDER - IPF	97,798	0	97,798	7,146	13.69	
41.00	SUBPROVIDER - IRF	51,994	0	51,994	2,396	21.70	
200.00	Total (Lines 30 through 199)	149,792		149,792	9,542	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	0	0				
40.00	SUBPROVIDER - IPF	3,919	53,651				
41.00	SUBPROVIDER - IRF	407	8,832				
200.00	Total (Lines 30 through 199)	4,326	62,483				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0033	Period: From 12/01/2016 To 11/30/2017	Worksheet D Part II Date/Time Prepared: 4/30/2018 2:19 pm
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Cost Center Description		Title XIX			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>						
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,123	12,854,964	0.000087	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
60.00	06000 LABORATORY	2,013	9,259,202	0.000217	0	0 60.00
65.00	06500 RESPIRATORY THERAPY	10	155,354	0.000064	0	0 65.00
66.00	06600 PHYSICAL THERAPY	23,481	5,579,227	0.004209	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
73.00	07300 DRUGS CHARGED TO PATIENTS	15,505	6,483,880	0.002391	0	0 73.00
76.00	03020 MENTAL HEALTH ANCILLARY	21,069	4,502,287	0.004680	0	0 76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00	09100 EMERGENCY	68,384	27,500,252	0.002487	0	0 91.00
200.00	Total (lines 50 through 199)	131,585	66,335,166		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0033	Period: From 12/01/2016 To 11/30/2017	Worksheet D Part III Date/Time Prepared: 4/30/2018 2:19 pm
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Cost Center Description			Title XIX		Hospital		PPS		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	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 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0.00	0	30.00	
40.00	04000	SUBPROVIDER - IPF	0	0	7,146	0.00	3,919	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	2,396	0.00	407	41.00	
200.00		Total (lines 30 through 199)	0	0	9,542		4,326	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
40.00	04000	SUBPROVIDER - IPF	0						40.00
41.00	04100	SUBPROVIDER - IRF	0						41.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0033	Period: From 12/01/2016 To 11/30/2017	Worksheet D Part IV Date/Time Prepared: 4/30/2018 2:19 pm
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Cost Center Description	Title XIX				Hospital		PPS
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
	1.00	2A	2.00	3A	3.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
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
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
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>							
91.00	09100	EMERGENCY	0	0	0	0	91.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0033	Period: From 12/01/2016 To 11/30/2017	Worksheet D Part IV Date/Time Prepared: 4/30/2018 2:19 pm
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Cost Center Description	Title XIX			Hospital	PPS			
	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)			
	4.00	5.00	6.00	7.00	8.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,854,964	0.000000	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
60.00	06000	LABORATORY	0	0	0	9,259,202	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	155,354	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,579,227	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,483,880	0.000000	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0	0	0	4,502,287	0.000000	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100	EMERGENCY	0	0	0	27,500,252	0.000000	91.00
200.00		Total (lines 50 through 199)	0	0	0	66,335,166		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet D  
Part IV  
Date/Time Prepared:  
4/30/2018 2:19 pm

Cost Center Description		Title XIX			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0 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
60.00	06000	LABORATORY	0.000000	0	0	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0 68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0 73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0.000000	0	0	0	0 76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	EMERGENCY	0.000000	0	0	0	0 91.00
200.00		Total (lines 50 through 199)		0	0	0	0 200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0033	Period: From 12/01/2016 To 11/30/2017	Worksheet D-1 Date/Time Prepared: 4/30/2018 2:19 pm
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)		0	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		0	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)		0	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		0	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)		0	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)		0	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)		0.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		0	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		0	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0033	Period: From 12/01/2016 To 11/30/2017	Worksheet D-1 Date/Time Prepared: 4/30/2018 2:19 pm	
Cost Center Description			Title XVIII		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)				0	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges				0	54.00
55.00	Target amount per discharge				0.00	55.00
56.00	Target amount (line 54 x line 55)				0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0	57.00
58.00	Bonus payment (see instructions)				0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0	61.00
62.00	Relief payment (see instructions)				0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)				0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0033		Period: From 12/01/2016 To 11/30/2017		Worksheet D-1 Date/Time Prepared: 4/30/2018 2:19 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0033 Component CCN: 14-S033	Period: From 12/01/2016 To 11/30/2017	Worksheet D-1 Date/Time Prepared: 4/30/2018 2:19 pm
		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)		7,146	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,146	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)		7,146	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)		1,156	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)		5,853,787	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,853,787	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)		5,853,787	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)		819.17	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		946,961	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)		946,961	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0033 Component CCN: 14-S033		Period: From 12/01/2016 To 11/30/2017		Worksheet D-1 Date/Time Prepared: 4/30/2018 2:19 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)					157,366	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,104,327	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)					15,826	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,695	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					18,521	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,085,806	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: 14-0033 Component CCN: 14-S033		Period: From 12/01/2016 To 11/30/2017		Worksheet D-1 Date/Time Prepared: 4/30/2018 2:19 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	97,798	5,853,787	0.016707	0	0	90.00
91.00	Nursing School cost	0	5,853,787	0.000000	0	0	91.00
92.00	Allied health cost	0	5,853,787	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,853,787	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0033 Component CCN: 14-T033	Period: From 12/01/2016 To 11/30/2017	Worksheet D-1 Date/Time Prepared: 4/30/2018 2:19 pm
		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)		2,396	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,396	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)		2,396	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)		1,548	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)		2,726,504	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)		2,726,504	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)		2,726,504	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)		1,137.94	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,761,531	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)		1,761,531	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0033 Component CCN: 14-T033		Period: From 12/01/2016 To 11/30/2017		Worksheet D-1 Date/Time Prepared: 4/30/2018 2:19 pm			
		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)	937,470						48.00	
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,699,001						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)	33,592						50.00	
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	17,840						51.00	
52.00	Total Program excludable cost (sum of lines 50 and 51)	51,432						52.00	
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,647,569						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: 14-0033 Component CCN: 14-T033		Period: From 12/01/2016 To 11/30/2017		Worksheet D-1 Date/Time Prepared: 4/30/2018 2:19 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	51,994	2,726,504	0.019070	0	0	90.00
91.00	Nursing School cost	0	2,726,504	0.000000	0	0	91.00
92.00	Allied health cost	0	2,726,504	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,726,504	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0033	Period: From 12/01/2016 To 11/30/2017	Worksheet D-1 Date/Time Prepared: 4/30/2018 2:19 pm
Cost Center Description		Title XIX	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)		0	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		0	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)		0	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		0	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)		0	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)		0	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)		0.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		0	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		0	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0033	Period: From 12/01/2016 To 11/30/2017	Worksheet D-1 Date/Time Prepared: 4/30/2018 2:19 pm	
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)				0	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges				0	54.00
55.00	Target amount per discharge				0.00	55.00
56.00	Target amount (line 54 x line 55)				0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0	57.00
58.00	Bonus payment (see instructions)				0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0	61.00
62.00	Relief payment (see instructions)				0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)				0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0033		Period: From 12/01/2016 To 11/30/2017		Worksheet D-1 Date/Time Prepared: 4/30/2018 2:19 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0033 Component CCN: 14-S033	Period: From 12/01/2016 To 11/30/2017	Worksheet D-3 Date/Time Prepared: 4/30/2018 2:19 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
40.00	04000	SUBPROVIDER - IPF		4,157,958	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.033292	28,203	939
54.01	05401	ULTRA SOUND	0.000000	0	0
57.00	05700	CT SCAN	0.000000	0	0
60.00	06000	LABORATORY	0.179229	266,855	47,828
65.00	06500	RESPIRATORY THERAPY	0.005420	0	0
66.00	06600	PHYSICAL THERAPY	0.214505	720	154
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.100351	618,264	62,043
76.00	03020	MENTAL HEALTH ANCILLARY	0.253455	59,143	14,990
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100	EMERGENCY	0.089099	352,555	31,412
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,325,740	157,366
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0
202.00		Net charges (line 200 minus line 201)		1,325,740	157,366

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0033 Component CCN: 14-T033	Period: From 12/01/2016 To 11/30/2017	Worksheet D-3 Date/Time Prepared: 4/30/2018 2:19 pm		
		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		4,173,222	41.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.033292	94,866	3,158	54.00
54.01	05401	ULTRA SOUND	0.000000	0	0	54.01
57.00	05700	CT SCAN	0.000000	0	0	57.00
60.00	06000	LABORATORY	0.179229	318,605	57,103	60.00
65.00	06500	RESPIRATORY THERAPY	0.005420	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.214505	3,531,156	757,451	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.100351	1,078,980	108,277	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0.253455	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00	09100	EMERGENCY	0.089099	128,858	11,481	91.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,152,465	937,470	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00		Net charges (line 200 minus line 201)		5,152,465		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0033	Period: From 12/01/2016 To 11/30/2017	Worksheet E Part A Date/Time Prepared: 4/30/2018 2:19 pm
		Title XVIII	Hospital	PPS
		1.00		
<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)		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		0	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)		30.00	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 § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		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 § 422 of the MMA</b>				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment ( sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	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)		0.00	31.00
32.00	Sum of lines 30 and 31		0.00	32.00
33.00	Allowable disproportionate share percentage (see instructions)		0.00	33.00
34.00	Disproportionate share adjustment (see instructions)		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0033	Period: From 12/01/2016 To 11/30/2017	Worksheet E Part A Date/Time Prepared: 4/30/2018 2:19 pm	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
<b>Uncompensated Care Adjustment</b>					
35.00	Total uncompensated care amount (see instructions)		5,977,483,147	6,766,695,164	35.00
35.01	Factor 3 (see instructions)		0.000066772	0.000053732	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		0	0	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
			Before 1/1	On/After 1/1	
			1.00	1.01	
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)		0		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			0	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			0	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
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see 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)			0	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			0	61.00
62.00	Deductibles billed to program beneficiaries			0	62.00
63.00	Coinurance 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)			0	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0033	Period: From 12/01/2016 To 11/30/2017	Worksheet E Part A Date/Time Prepared: 4/30/2018 2:19 pm	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0		0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			0	71.00
71.01	Sequestration adjustment (see instructions)			0	71.01
71.02	Demonstration payment adjustment amount after sequestration			0	71.02
72.00	Interim payments			0	72.00
73.00	Tentative settlement (for contractor use only)			0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)			0	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0033	Period: From 12/01/2016 To 11/30/2017	Worksheet E Part B Date/Time Prepared: 4/30/2018 2:19 pm
		Title XVIII	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)			383,865 2.00
3.00	OPPS payments			345,129 3.00
4.00	Outlier payment (see instructions)			0 4.00
4.01	Outlier reconciliation amount (see instructions)			0 4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			0 11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (see instructions)			0 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			345,129 24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)			6,886 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			67,851 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)			270,392 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)			270,392 30.00
31.00	Primary payer payments			553 31.00
32.00	Subtotal (line 30 minus line 31)			269,839 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)			49,413 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			32,118 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			40,648 36.00
37.00	Subtotal (see instructions)			301,957 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS			-13 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 39.50
39.97	Demonstration payment adjustment amount before sequestration			0 39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			301,944 40.00
40.01	Sequestration adjustment (see instructions)			6,039 40.01
40.02	Demonstration payment adjustment amount after sequestration			0 40.02
41.00	Interim payments			264,454 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			31,451 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: 14-0033	Period: From 12/01/2016 To 11/30/2017	Worksheet E Part B Date/Time Prepared: 4/30/2018 2:19 pm
		Component CCN: 14-S033		
		Title XVIII	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)		35,460	2.00
3.00	OPPS payments		18,004	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		18,004	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		147	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		3,542	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)		14,315	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)		14,315	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		14,315	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)		14,315	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		14,315	40.00
40.01	Sequestration adjustment (see instructions)		286	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		14,029	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0033 Component CCN: 14-T033	Period: From 12/01/2016 To 11/30/2017	Worksheet E Part B Date/Time Prepared: 4/30/2018 2:19 pm
		Title XVIII	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	OPPS payments		105	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		105	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)		105	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)		105	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		105	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)		105	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		105	40.00
40.01	Sequestration adjustment (see instructions)		2	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		103	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet E-1  
Part I  
Date/Time Prepared:  
4/30/2018 2:19 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		0		264,454		1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		0		264,454		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		31,451		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		0		295,905		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: 14-0033  
Component CCN: 14-S033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet E-1  
Part I  
Date/Time Prepared:  
4/30/2018 2:19 pm

Title XVIII

Subprovider -  
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		877,442		14,029	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		68,220		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)		945,662		14,029	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		4,383		0	6.02
7.00	Total Medicare program liability (see instructions)		941,279		14,029	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: 14-0033  
Component CCN: 14-T033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet E-1  
Part I  
Date/Time Prepared:  
4/30/2018 2:19 pm

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		2,180,568		103	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)		2,180,568		103	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		24,931		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,205,499		103	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: 14-0033	Period: From 12/01/2016 To 11/30/2017	Worksheet E-1 Part II Date/Time Prepared: 4/30/2018 2:19 pm
		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
<b>INPATIENT HOSPITAL SERVICES UNDER THE IPPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0033	Period: From 12/01/2016 To 11/30/2017	Worksheet E-3 Part III Date/Time Prepared: 4/30/2018 2:19 pm
		Title XVIII	Hospital	PPS
		1.00		
<b>PART III - MEDICARE PART A SERVICES - IRF PPS</b>				
1.00	Net Federal PPS Payment (see instructions)		0	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0.0000	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		0	3.00
4.00	Outlier Payments		0	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)		0.000000	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)		0	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)		0	17.00
18.00	Primary payer payments		0	18.00
19.00	Subtotal (line 17 less line 18).		0	19.00
20.00	Deductibles		0	20.00
21.00	Subtotal (line 19 minus line 20)		0	21.00
22.00	Coinsurance		0	22.00
23.00	Subtotal (line 21 minus line 22)		0	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)		0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	26.00
27.00	Subtotal (sum of lines 23 and 25)		0	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	Demonstration payment adjustment amount before sequestration		0	31.99
32.00	Total amount payable to the provider (see instructions)		0	32.00
32.01	Sequestration adjustment (see instructions)		0	32.01
32.02	Demonstration payment adjustment amount after sequestration		0	32.02
33.00	Interim payments		0	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, 32.02, 33, and 34)		0	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		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: 14-0033 Component CCN: 14-S033	Period: From 12/01/2016 To 11/30/2017	Worksheet E-3 Part II Date/Time Prepared: 4/30/2018 2:19 pm
		Title XVIII	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)			1,010,477 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)			19,578,082 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)			1,010,477 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)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			1,010,477 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			1,010,477 18.00
19.00	Deductibles			108,864 19.00
20.00	Subtotal (line 18 minus line 19)			901,613 20.00
21.00	Coinsurance			6,251 21.00
22.00	Subtotal (line 20 minus line 21)			895,362 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			100,196 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			65,127 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			75,596 25.00
26.00	Subtotal (sum of lines 22 and 24)			960,489 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	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			960,489 31.00
31.01	Sequestration adjustment (see instructions)			19,210 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			945,662 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			-4,383 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: 14-0033 Component CCN: 14-T033	Period: From 12/01/2016 To 11/30/2017	Worksheet E-3 Part III Date/Time Prepared: 4/30/2018 2:19 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
<b>PART III - MEDICARE PART A SERVICES - IRF PPS</b>				
1.00	Net Federal PPS Payment (see instructions)			2,129,747 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0315 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			112,025 3.00
4.00	Outlier Payments			11,804 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)			6.564384 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)			2,253,576 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)			2,253,576 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			2,253,576 19.00
20.00	Deductibles			5,208 20.00
21.00	Subtotal (line 19 minus line 20)			2,248,368 21.00
22.00	Coinsurance			987 22.00
23.00	Subtotal (line 21 minus line 22)			2,247,381 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			4,812 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			3,128 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			1,260 26.00
27.00	Subtotal (sum of lines 23 and 25)			2,250,509 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	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			2,250,509 32.00
32.01	Sequestration adjustment (see instructions)			45,010 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			2,180,568 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, 32.02, 33, and 34)			24,931 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			14,056 36.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			11,804 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: 14-0033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet G

Date/Time Prepared:  
4/30/2018 2:19 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	579	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	4,911,834	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,223,715	0	0	0	6.00
7.00	Inventory	139,710	0	0	0	7.00
8.00	Prepaid expenses	56,942	0	0	0	8.00
9.00	Other current assets	46,268	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)	2,931,618	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	-2,666,676	0	0	0	14.00
15.00	Buildings	13,181,395	0	0	0	15.00
16.00	Accumulated depreciation	-3,986,046	0	0	0	16.00
17.00	Leasehold improvements	1,312,822	0	0	0	17.00
18.00	Accumulated depreciation	-850,029	0	0	0	18.00
19.00	Fixed equipment	1,404,632	0	0	0	19.00
20.00	Accumulated depreciation	-654,839	0	0	0	20.00
21.00	Automobiles and trucks	17,338	0	0	0	21.00
22.00	Accumulated depreciation	-17,338	0	0	0	22.00
23.00	Major movable equipment	2,216,837	0	0	0	23.00
24.00	Accumulated depreciation	-2,115,332	0	0	0	24.00
25.00	Minor equipment depreciable	1,389,960	0	0	0	25.00
26.00	Accumulated depreciation	-1,370,714	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)	16,383,379	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	-236,020	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	-236,020	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	19,078,977	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	558,857	0	0	0	37.00
38.00	Salaries, wages, and fees payable	512,098	0	0	0	38.00
39.00	Payroll taxes payable	57,912	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	-2,029,633	0	0	0	43.00
44.00	Other current liabilities	828,663	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-72,103	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)	-72,103	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	19,151,080				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)	19,151,080	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	19,078,977	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet G-1

Date/Time Prepared:  
4/30/2018 2:19 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		21,561,141		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-2,410,061			2.00
3.00	Total (sum of line 1 and line 2)		19,151,080		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)		19,151,080		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)		19,151,080		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: 14-0033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
4/30/2018 2:19 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	0		0	1.00
2.00	SUBPROVIDER - IPF	25,620,808		25,620,808	2.00
3.00	SUBPROVIDER - IRF	6,459,328		6,459,328	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)	32,080,136		32,080,136	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)	32,080,136		32,080,136	17.00
18.00	Ancillary services	14,504,099	2,177,792	16,681,891	18.00
19.00	Outpatient services	0	49,653,275	49,653,275	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	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)	46,584,235	51,831,067	98,415,302	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		19,985,463		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)		19,985,463		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0033

Period:  
From 12/01/2016  
To 11/30/2017

Worksheet G-3

Date/Time Prepared:  
4/30/2018 2:19 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	98,415,302	1.00
2.00	Less contractual allowances and discounts on patients' accounts	80,880,088	2.00
3.00	Net patient revenues (line 1 minus line 2)	17,535,214	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	19,985,463	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,450,249	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	40,188	24.00
25.00	Total other income (sum of lines 6-24)	40,188	25.00
26.00	Total (line 5 plus line 25)	-2,410,061	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)	-2,410,061	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0033	Period: From 12/01/2016 To 11/30/2017	Worksheet L Parts I-III Date/Time Prepared: 4/30/2018 2:19 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier			0 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)		0.00	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)		0	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