

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: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet S Parts I-III Date/Time Prepared: 4/30/2018 2:16 pm
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PART I - COST REPORT STATUS

Provider use only 1. Electronically filed cost report Date: 4/30/2018 Time: 2:16 pm
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only 5. Cost Report Status 6. Date Received:
 (1) As Submitted 7. Contractor No. 10. NPR Date:
 (2) Settled without Audit 8. Initial Report for this Provider CCN 11. Contractor's Vendor Code: 4
 (3) Settled with Audit 9. Final Report for this Provider CCN 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.
 (4) Reopened
 (5) Amended

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 - EAST (14-0084) 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	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	413,059	28,301	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
200.00 Total	0	413,059	28,301	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-MEDI CARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0084		Period: From 12/01/2016 To 11/30/2017		Worksheet S-2 Part I Date/Time Prepared: 4/30/2018 2:15 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			
		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	
		VISTA MEDICAL CENTER - EAST		140084	29404	1	07/01/1966	N	P P	
3.00	Hospital and Hospital-Based Component Identification:								3.00	
	Hospital									
4.00	Subprovider - IPF								4.00	
5.00	Subprovider - IRF								5.00	
6.00	Subprovider - (Other)								6.00	
7.00	Swing Beds - SNF								7.00	
8.00	Swing Beds - NF								8.00	
9.00	Hospital-Based SNF								9.00	
10.00	Hospital-Based NF								10.00	
11.00	Hospital-Based OLTC								11.00	
12.00	Hospital-Based HHA								12.00	
13.00	Separately Certified ASC								13.00	
14.00	Hospital-Based Hospice								14.00	
15.00	Hospital-Based Health Clinic - RHC								15.00	
16.00	Hospital-Based Health Clinic - FQHC								16.00	
17.00	Hospital-Based (CMHC) I								17.00	
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.						Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.							3	N	23.00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	2,225	1,709	25	18	10,307	345		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0		25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet S-2 Part I Date/Time Prepared: 4/30/2018 2:15 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		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	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.			N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	76.00

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						1.00			
Long Term Care Hospital PPS									
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.					N		81.00	
TEFRA Providers									
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.							86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.					N		87.00	
						V	XIX		
						1.00	2.00		
Title V and XIX Services									
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.					N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.					N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.						N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.					N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.					N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.					0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.					N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.					0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 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	
Rural Providers									
105.00	Does this hospital qualify as a CAH?					N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					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: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet S-2 Part I Date/Time Prepared: 4/30/2018 2:15 pm		
		1.00	2.00			
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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:	164,821	0	0		
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		HB0776		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet S-2 Part I Date/Time Prepared: 4/30/2018 2:15 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: 52280		
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.				Y	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N	146.00
					1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N	149.00
		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)						
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
					1.00	
Multi campus						
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00
		Name	County	State	Zip Code	CBSA
		0	1.00	2.00	3.00	4.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)				0.00	166.00
					1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act						
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.				Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)				0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)				9.99	169.00
		Beginning	Ending			
		1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)				06/02/2017	08/30/2017
					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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0084		Period: From 12/01/2016 To 11/30/2017		Worksheet S-2 Part II Date/Time Prepared: 4/30/2018 2:15 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.				Y		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	02/27/2018	Y	02/27/2018		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: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet S-2 Part II Date/Time Prepared: 4/30/2018 2:15 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
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
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
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N	31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N	35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		Y	12/31/2016
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N	40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet S-2 Part II Date/Time Prepared: 4/30/2018 2:15 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REVENUE MANAGER		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: 14-0084

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

Worksheet S-3
Part I
Date/Time Prepared:
4/30/2018 2:15 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	167	60,955	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)		167	60,955	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	23	8,395	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		190	69,350	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER						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	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		190				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: 14-0084

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

Worksheet S-3
Part I
Date/Time Prepared:
4/30/2018 2:15 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)	15,243	1,365	37,633			1.00
2.00 HMO and other (see instructions)	4,514	9,575				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	15,243	1,365	37,633			7.00
8.00 INTENSIVE CARE UNIT	2,050	125	4,908			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		3,219	3,554			13.00
14.00 Total (see instructions)	17,293	4,709	46,095	0.00	785.25	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	0	0	0	0.00	0.05	16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	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	0	0	0	0.00	0.00	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0	0	0	0.00	0.00	24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	785.30	27.00
28.00 Observation Bed Days		0	3,039			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	345	548			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: 14-0084

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

Worksheet S-3
Part I
Date/Time Prepared:
4/30/2018 2:15 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	3,388	3,363	10,271	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	3,388	3,363	10,271	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	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	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 14-0084		Period: From 12/01/2016 To 11/30/2017		Worksheet S-3 Part II Date/Time Prepared: 4/30/2018 2:15 pm	
	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	53,199,651	0	53,199,651	1,633,434.00	32.57	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		261,476	391,165	652,641	16,236.00	40.20	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract Labor: Direct Patient Care		654,469	0	654,469	13,206.00	49.56	11.00
12.00	Contract labor: Top level management and other management and administrative services		1,117,367	0	1,117,367	13,240.00	84.39	12.00
13.00	Contract Labor: Physician-Part A - Administrative		76,520	0	76,520	588.00	130.14	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		1,357,253	0	1,357,253	21,158.00	64.15	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		10,668,247	0	10,668,247			17.00
18.00	Wage-related costs (other) (see instructions)		26,782	0	26,782			18.00
19.00	Excluded areas		121,384	0	121,384			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	380,101	0	380,101	7,354.00	51.69	26.00
27.00	Administrative & General	5.00	5,026,794	-393,634	4,633,160	181,863.00	25.48	27.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0084

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

Worksheet S-3
Part II
Date/Time Prepared:
4/30/2018 2:15 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.)	1,287,524	0	1,287,524	37,955.00	33.92	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	952,770	0	952,770	34,851.00	27.34	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	3,153,920	0	3,153,920	66,688.00	47.29	38.00
39.00	Central Services and Supply	408,438	0	408,438	25,681.00	15.90	39.00
40.00	Pharmacy	1,637,490	0	1,637,490	40,954.00	39.98	40.00
41.00	Medical Records & Medical Records Library	986,521	0	986,521	40,151.00	24.57	41.00
42.00	Social Service	0	0	0	69.00	0.00	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0084

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

Worksheet S-3
Part III
Date/Time Prepared:
4/30/2018 2:15 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	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	54,487,175	0	54,487,175	1,671,389.00	32.60	1.00
2.00	Excluded area salaries (see instructions)	261,476	391,165	652,641	16,236.00	40.20	2.00
3.00	Subtotal salaries (line 1 minus line 2)	54,225,699	-391,165	53,834,534	1,655,153.00	32.53	3.00
4.00	Subtotal other wages & related costs (see inst.)	3,205,609	0	3,205,609	48,192.00	66.52	4.00
5.00	Subtotal wage-related costs (see inst.)	10,695,029	0	10,695,029	0.00	19.87	5.00
6.00	Total (sum of lines 3 thru 5)	68,126,337	-391,165	67,735,172	1,703,345.00	39.77	6.00
7.00	Total overhead cost (see instructions)	13,833,558	-393,634	13,439,924	435,566.00	30.86	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet S-3 Part IV Date/Time Prepared: 4/30/2018 2:15 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			932,742 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
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			4,902,634 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			42,328 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			40,388 11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			-2,715 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			187,161 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			526,646 15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)			0 16.00
TAXES				
17.00	FICA-Employers Portion Only			3,100,484 17.00
18.00	Medicare Taxes - Employers Portion Only			725,113 18.00
19.00	Unemployment Insurance			0 19.00
20.00	State or Federal Unemployment Taxes			308,067 20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			0 21.00
22.00	Day Care Cost and Allowances			0 22.00
23.00	Tuition Reimbursement			0 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			10,762,848 24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			26,782 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet S-3 Part V Date/Time Prepared: 4/30/2018 2:15 pm
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	654,469	10,762,848	1.00
2.00	Hospital	654,469	10,762,848	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet S-10 Date/Time Prepared: 4/30/2018 2:15 pm
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			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.101276	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		22,515,303	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		12,378,662	5.00
6.00	Medicaid charges		354,214,917	6.00
7.00	Medicaid cost (line 1 times line 6)		35,873,470	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)		979,505	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		1,860	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		188	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		188	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)		979,693	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)	38,444,470	281,709	38,726,179
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,893,502	281,709	4,175,211
22.00	Payments received from patients for amounts previously written off as charity care	100,063	3,959	104,022
23.00	Cost of charity care (line 21 minus line 22)	3,793,439	277,750	4,071,189
			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?			24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0
26.00	Total bad debt expense for the entire hospital complex (see instructions)			16,601,917
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			1,166,309
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			1,794,322
28.00	Non-Medicare bad debt expense (see instructions)			14,807,595
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			2,127,667
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			6,198,856
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			7,178,549

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 14-0084		Period: From 12/01/2016 To 11/30/2017		Worksheet A	
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		3,044,984	3,044,984	142,127	3,187,111	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,679,525	4,679,525	3,594,834	8,274,359	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	380,101	329,328	709,429	6,636,805	7,346,234	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,026,794	37,241,157	42,267,951	-7,983,436	34,284,515	5.00
7.00	00700	OPERATION OF PLANT	952,770	3,881,644	4,834,414	-92,575	4,741,839	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	624,381	624,381	0	624,381	8.00
9.00	00900	HOUSEKEEPING	0	2,191,133	2,191,133	-74	2,191,059	9.00
10.00	01000	DIETARY	0	2,716,454	2,716,454	-2,469	2,713,985	10.00
13.00	01300	NURSING ADMINISTRATION	3,153,920	636,580	3,790,500	-949	3,789,551	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	408,438	9,079,060	9,487,498	-8,572,518	914,980	14.00
15.00	01500	PHARMACY	1,637,490	5,618,460	7,255,950	-5,121,921	2,134,029	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	986,521	1,212,575	2,199,096	-10,507	2,188,589	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,417,692	4,246,464	15,664,156	-144,384	15,519,772	30.00
31.00	03100	INTENSIVE CARE UNIT	3,493,651	1,249,088	4,742,739	-5,106	4,737,633	31.00
40.00	04000	SUBPROVIDER - I PF	2,192	210	2,402	-2,402	0	40.00
41.00	04100	SUBPROVIDER - I RF	277	368	645	-645	0	41.00
43.00	04300	NURSERY	843,299	169,328	1,012,627	298,951	1,311,578	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,939,565	4,654,338	7,593,903	-1,115,193	6,478,710	50.00
51.00	05100	RECOVERY ROOM	1,526,727	140,222	1,666,949	-1,408	1,665,541	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,613,787	633,326	2,247,113	-169,214	2,077,899	52.00
53.00	05300	ANESTHESIOLOGY	37,696	1,384,038	1,421,734	0	1,421,734	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,569,064	2,851,695	6,420,759	1,549,801	7,970,560	54.00
54.01	05401	ULTRASOUND	502,983	86,413	589,396	-589,396	0	54.01
56.00	05600	RADIOISOTOPE	252,471	424,695	677,166	-677,166	0	56.00
57.00	05700	CT SCAN	429,954	316,185	746,139	-820,587	-74,448	57.00
58.00	05800	MRI	169,969	216,945	386,914	-386,914	0	58.00
60.00	06000	LABORATORY	3,337,503	3,963,416	7,300,919	-184,559	7,116,360	60.00
65.00	06500	RESPIRATORY THERAPY	991,274	602,253	1,593,527	-328,136	1,265,391	65.00
66.00	06600	PHYSICAL THERAPY	2,101,284	665,253	2,766,537	325,120	3,091,657	66.00
67.00	06700	OCCUPATIONAL THERAPY	317,951	24,630	342,581	-342,581	0	67.00
68.00	06800	SPEECH PATHOLOGY	192,063	15,669	207,732	-207,732	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,803,514	1,157,528	2,961,042	-118,439	2,842,603	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,305,843	3,305,843	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,270,099	5,270,099	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,940,037	4,940,037	73.00
74.00	07400	RENAL DIALYSIS	0	948,157	948,157	0	948,157	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.02	03951	GUIDANCE	117,246	38,468	155,714	-96	155,618	76.02
76.03	03952	WOUND CARE	259,700	316,886	576,586	-576,586	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	4,474,748	4,367,181	8,841,929	522,940	9,364,869	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	259,007	260,643	519,650	-110	519,540	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	53,199,651	99,988,680	153,188,331	-868,546	152,319,785	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	-35,346	-35,346	47,233	11,887	192.00
194.00	07950	CLINIC CORPORATION	0	0	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	53,688	53,688	715,396	769,084	194.02
194.03	07953	VISTA MEDICAL CENTER WEST	0	0	0	105,917	105,917	194.03
194.04	07954	ABBOTT RESEARCH	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	53,199,651	100,007,022	153,206,673	0	153,206,673	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0084

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

Worksheet A
Date/Time Prepared:
4/30/2018 2:15 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	232,226	3,419,337	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-1,918,306	6,356,053	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-11,785	7,334,449	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-13,543,832	20,740,683	5.00
7.00	00700	OPERATION OF PLANT	-225,686	4,516,153	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	624,381	8.00
9.00	00900	HOUSEKEEPING	-753,038	1,438,021	9.00
10.00	01000	DIETARY	-3,490	2,710,495	10.00
13.00	01300	NURSING ADMINISTRATION	-86,609	3,702,942	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	914,980	14.00
15.00	01500	PHARMACY	0	2,134,029	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3,279	2,185,310	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,465,969	13,053,803	30.00
31.00	03100	INTENSIVE CARE UNIT	-232,750	4,504,883	31.00
40.00	04000	SUBPROVIDER - I PF	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	41.00
43.00	04300	NURSERY	0	1,311,578	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-1,068,676	5,410,034	50.00
51.00	05100	RECOVERY ROOM	-3,125	1,662,416	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,077,899	52.00
53.00	05300	ANESTHESIOLOGY	-1,125,202	296,532	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-22,471	7,948,089	54.00
54.01	05401	ULTRASOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	-74,448	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	-6,638	7,109,722	60.00
65.00	06500	RESPIRATORY THERAPY	-6,800	1,258,591	65.00
66.00	06600	PHYSICAL THERAPY	0	3,091,657	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	-200,399	2,642,204	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,305,843	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,270,099	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-487	4,939,550	73.00
74.00	07400	RENAL DIALYSIS	0	948,157	74.00
76.00	03020	CARDIAC REHAB	0	0	76.00
76.02	03951	GUI DANCE	0	155,618	76.02
76.03	03952	WOUND CARE	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
91.00	09100	EMERGENCY	-3,075,557	6,289,312	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-328,024	191,516	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-24,849,897	127,469,888	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	11,887	192.00
194.00	07950	CLINIC CORPORATION	0	0	194.00
194.01	07951	SENIOR CIRCLE	0	0	194.01
194.02	07952	MARKETING	0	769,084	194.02
194.03	07953	VISTA MEDICAL CENTER WEST	0	105,917	194.03
194.04	07954	ABBOTT RESEARCH	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-24,849,897	128,356,776	200.00

RECLASSIFICATIONS

Provider CCN: 14-0084

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

Worksheet A-6

Date/Time Prepared:
4/30/2018 2:15 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - RECLASS EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6,640,598	1.00
	O		0	6,640,598	
B - RECLASS OXYGEN COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	83,435	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
	O		0	83,435	
C - RECLASS LEASE AND RENTAL EXP					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,581,074	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
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
	O		0	3,581,074	
D - RECLASS OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	142,127	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	13,760	2.00
	O		0	155,887	
E - RECLASS MARKETING DEPT					
1.00	MARKETING	194.02	240,484	474,912	1.00
	O		240,484	474,912	
F - RECLASS COST OF DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,940,037	1.00
	O		0	4,940,037	
G - RECLASS LABOR & DELIVERY COSTS					
1.00	NURSERY	43.00	115,043	193,109	1.00
2.00		0.00	0	0	2.00
	O		115,043	193,109	
H - RECLASS PT, OT AND SP COSTS					
1.00	PHYSICAL THERAPY	66.00	510,014	40,299	1.00
2.00		0.00	0	0	2.00
	O		510,014	40,299	
I - RECLASS MISC DEPTS					
1.00	ADULTS & PEDIATRICS	30.00	2,469	578	1.00
2.00	EMERGENCY	91.00	259,700	316,886	2.00
3.00		0.00	0	0	3.00
	O		262,169	317,464	
J - RECLASS OTHER RADIOLOGY COSTS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	1,355,377	929,219	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
	O		1,355,377	929,219	
L - ALLOCATION TO VISTA WEST					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	47,233	0	1.00
2.00	VISTA MEDICAL CENTER WEST	194.03	105,917	0	2.00
	O		153,150	0	

RECLASSIFICATIONS

Provider CCN: 14-0084

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

Worksheet A-6

Date/Time Prepared:
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Increases					
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
M - RECLASS MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	3,222,408	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	5,270,099	2.00
3.00		0.00	0	0	3.00
				8,492,507	
500.00	Grand Total: Increases		2,636,237	25,848,541	500.00

RECLASSIFICATIONS

Provider CCN: 14-0084

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

Worksheet A-6
Date/Time Prepared:
4/30/2018 2:15 pm

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
A - RECLASS EMPLOYEE BENEFITS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,640,598	0		1.00
	O		0	6,640,598			
B - RECLASS OXYGEN COSTS							
1.00	OPERATING ROOM	50.00	0	9,740	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,365	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	71,090	0		3.00
4.00	EMERGENCY	91.00	0	240	0		4.00
	O		0	83,435			
C - RECLASS LEASE AND RENTAL EXP							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,793	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	318,405	0		2.00
3.00	OPERATION OF PLANT	7.00	0	92,575	0		3.00
4.00	HOUSEKEEPING	9.00	0	74	0		4.00
5.00	DIETARY	10.00	0	2,469	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	949	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	94,174	0		7.00
8.00	PHARMACY	15.00	0	181,884	0		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	10,507	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	6,718	0		10.00
11.00	INTENSIVE CARE UNIT	31.00	0	5,106	0		11.00
12.00	NURSERY	43.00	0	9,201	0		12.00
13.00	OPERATING ROOM	50.00	0	1,089,975	0		13.00
14.00	RECOVERY ROOM	51.00	0	1,408	0		14.00
15.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1,775	0		15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	734,795	0		16.00
17.00	ULTRASOUND	54.01	0	740	0		17.00
18.00	RADIOISOTOPE	56.00	0	48	0		18.00
19.00	CT SCAN	57.00	0	74,491	0		19.00
20.00	MRI	58.00	0	114,188	0		20.00
21.00	LABORATORY	60.00	0	184,559	0		21.00
22.00	RESPIRATORY THERAPY	65.00	0	257,046	0		22.00
23.00	PHYSICAL THERAPY	66.00	0	225,193	0		23.00
24.00	ELECTROCARDIOLOGY	69.00	0	117,389	0		24.00
25.00	GUN DANCE	76.02	0	96	0		25.00
26.00	EMERGENCY	91.00	0	3,798	0		26.00
27.00	EMERGENCY	91.00	0	49,608	0		27.00
28.00	AMBULANCE SERVICES	95.00	0	110	0		28.00
	O		0	3,581,074			
D - RECLASS OTHER CAPITAL COSTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	155,887	12		1.00
2.00		0.00	0	0	13		2.00
	O		0	155,887			
E - RECLASS MARKETING DEPT							
1.00	ADMINISTRATIVE & GENERAL	5.00	240,484	474,912	0		1.00
	O		240,484	474,912			
F - RECLASS COST OF DRUGS							
1.00	PHARMACY	15.00	0	4,940,037	0		1.00
	O		0	4,940,037			
G - RECLASS LABOR & DELIVERY COSTS							
1.00	ADULTS & PEDIATRICS	30.00	10,229	130,484	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	104,814	62,625	0		2.00
	O		115,043	193,109			
H - RECLASS PT, OT AND SP COSTS							
1.00	OCCUPATIONAL THERAPY	67.00	317,951	24,630	0		1.00
2.00	SPEECH PATHOLOGY	68.00	192,063	15,669	0		2.00
	O		510,014	40,299			
I - RECLASS MISC DEPTS							
1.00	SUBPROVIDER - IPF	40.00	2,192	210	0		1.00
2.00	WOUND CARE	76.03	259,700	316,886	0		2.00
3.00	SUBPROVIDER - IRF	41.00	277	368	0		3.00
	O		262,169	317,464			
J - RECLASS OTHER RADIOLOGY COSTS							
1.00	ULTRASOUND	54.01	502,983	85,673	0		1.00
2.00	RADIOISOTOPE	56.00	252,471	424,647	0		2.00
3.00	CT SCAN	57.00	429,954	316,142	0		3.00
4.00	MRI	58.00	169,969	102,757	0		4.00
	O		1,355,377	929,219			
L - ALLOCATION TO VISTA WEST							
1.00	ADMINISTRATIVE & GENERAL	5.00	153,150	0	0		1.00
2.00		0.00	0	0	0		2.00
	O		153,150	0	0		

RECLASSIFICATIONS

Provider CCN: 14-0084

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

Worksheet A-6

Date/Time Prepared:
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Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
M - RECLASS MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	8,475,979	0	1.00
2.00	OPERATING ROOM	50.00	0	15,478	0	2.00
3.00	ELECTROCARDIOLOGY	69.00	0	1,050	0	3.00
	0		0	8,492,507		
500.00	Grand Total: Decreases		2,636,237	25,848,541		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0084

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

Worksheet A-7
Part I
Date/Time Prepared:
4/30/2018 2:15 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	67,659	0	0	0	0	1.00
2.00	Land Improvements	464,176	0	0	0	0	2.00
3.00	Buildings and Fixtures	96,552,768	17,599	0	17,599	0	3.00
4.00	Building Improvements	80,874,292	67,239	0	67,239	6,716	4.00
5.00	Fixed Equipment	4,488,996	543,754	0	543,754	4,779	5.00
6.00	Movable Equipment	35,217,507	782,999	0	782,999	1,754,750	6.00
7.00	HIT designated Assets	18,515,779	0	0	0	54,381	7.00
8.00	Subtotal (sum of lines 1-7)	236,181,177	1,411,591	0	1,411,591	1,820,626	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	236,181,177	1,411,591	0	1,411,591	1,820,626	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	67,659	0				1.00
2.00	Land Improvements	464,176	0				2.00
3.00	Buildings and Fixtures	96,570,367	0				3.00
4.00	Building Improvements	80,934,815	0				4.00
5.00	Fixed Equipment	5,027,971	0				5.00
6.00	Movable Equipment	34,245,756	0				6.00
7.00	HIT designated Assets	18,461,398	0				7.00
8.00	Subtotal (sum of lines 1-7)	235,772,142	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	235,772,142	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0084

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

Worksheet A-7
Part II
Date/Time Prepared:
4/30/2018 2:15 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	3,044,984	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,679,525	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	7,724,509	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	3,044,984				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4,679,525				2.00
3.00	Total (sum of lines 1-2)	0	7,724,509				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CCN: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet A-7 Part III Date/Time Prepared: 4/30/2018 2:15 pm
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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	178,037,017	0	178,037,017	0.754617	0
2.00	CAP REL COSTS-MVBLE EQUIP	57,893,361	0	57,893,361	0.245383	0
3.00	Total (sum of lines 1-2)	235,930,378	0	235,930,378	1.000000	0
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL	
		Taxes	Other Capital-Related Costs	Total (sum of col.s. 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	3,277,210	0
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,761,219	3,581,074
3.00	Total (sum of lines 1-2)	0	0	0	6,038,429	3,581,074
Cost Center Description		SUMMARY OF CAPITAL				
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of col.s. 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	142,127	0	0	3,419,337
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	13,760	0	6,356,053
3.00	Total (sum of lines 1-2)	0	142,127	13,760	0	9,775,390

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0084

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

Worksheet A-8

Date/Time Prepared:
4/30/2018 2:15 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	-102,880		ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)	A	-1,384		CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-8,294,829				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)	B	-1,040		RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-3,366,173				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-3,490		DIETARY	10.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients	B	-7		MEDICAL RECORDS & LIBRARY	16.00	0	16.00
17.00 Sale of drugs to other than patients	B	-487		DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00 Sale of medical records and abstracts	B	-3,272		MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines	B	-4,513		ADMINISTRATIVE & GENERAL	5.00	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	133,420		CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-1,926,983		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 INSERVICE EDUCATION REVENUE	B	-50		NURSING ADMINISTRATION	13.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0084

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

Worksheet A-8

Date/Time Prepared:
4/30/2018 2:15 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	3.00	
34.00 FITNESS REVENUE	B	-61,642	ADMINISTRATIVE & GENERAL		5.00	0 34.00
35.00 CARELINE REVENUE	B	-24,588	ADMINISTRATIVE & GENERAL		5.00	0 35.00
36.00 RENTAL INCOME	B	-24,134	CAP REL COSTS-BLDG & FIXT		1.00	9 36.00
37.00 OTHER MISC REVENUE	B	-10,500	ADMINISTRATIVE & GENERAL		5.00	0 37.00
38.00 DEPRECIATION - A&G	A	-570,959	ADMINISTRATIVE & GENERAL		5.00	0 38.00
39.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 39.00
40.00 NON-ALLOWABLE PHONE / TV	A	-188,253	ADMINISTRATIVE & GENERAL		5.00	0 40.00
40.01 NON-ALLOWABLE TV	A	-16,105	ADMINISTRATIVE & GENERAL		5.00	0 40.01
40.02 NON-ALLOWABLE PHONE DEPR	A	-20,311	CAP REL COSTS-MVBLE EQUIP		2.00	9 40.02
40.03 NON-ALLOWABLE PHONE / TV BENEFITS	A	-11,785	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 40.03
40.04 NON-RESTRICTED DONATION	A	-12,599	ADMINISTRATIVE & GENERAL		5.00	0 40.04
40.05 GRANT REVENUE	B	-20,000	ADMINISTRATIVE & GENERAL		5.00	0 40.05
41.00 PHYSICIAN RECRUITING	A	-207,130	ADMINISTRATIVE & GENERAL		5.00	0 41.00
42.00 STATE OPERATING TAX	A	-8,577,547	ADMINISTRATIVE & GENERAL		5.00	0 42.00
43.00 CLUB DUES AND LOBBYING	A	-67,129	ADMINISTRATIVE & GENERAL		5.00	0 43.00
44.00 LEGAL FEES	A	-146,146	ADMINISTRATIVE & GENERAL		5.00	0 44.00
44.01 ALLOCATED RECOVERY ROOM	A	-3,125	RECOVERY ROOM		51.00	0 44.01
44.02 ALLOCATED ANESTHESIA	A	-202	ANESTHESIOLOGY		53.00	0 44.02
44.03 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 44.03
44.04 AMBULANCE TRAINING	B	-328,024	AMBULANCE SERVICES		95.00	0 44.04
45.01 ALLOCATED SECURITY / PLANT OPS	A	-225,686	OPERATION OF PLANT		7.00	0 45.01
45.02 ALLOCATED HOUSEKEEPING	A	-753,038	HOUSEKEEPING		9.00	0 45.02
45.06 ALLOCATED EKG	A	-20,398	ELECTROCARDIOLOGY		69.00	0 45.06
45.07 ALLOCATED BUSINESS OFFICE FROM WEST	A	11,092	ADMINISTRATIVE & GENERAL		5.00	0 45.07
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-24,849,897				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: 14-0084
 Period: From 12/01/2016 To 11/30/2017
 Worksheet A-8-1
 Date/Time Prepared: 4/30/2018 2:15 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	0.00		0	0	1.00
2.00	0.00		0	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL MANAGEMENT FEES	0	4,606,454	3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT NEW CAPITAL BUILDING & FIXTU	122,940	0	4.00
4.01	2.00	CAP REL COSTS-MVBLE EQUIP NEW CAPITAL MOVABLE EQUIPMEN	30,372	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL NON-CAPITAL HOME OFFICE COST	1,015,800	0	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL MALPRACTICE COSTS	164,821	2,932,828	4.03
4.04	0.00		0	0	4.04
4.05	0.00		0	0	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL OHC SPECIFIC COSTS & OFFSET	2,839,176	0	4.06
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.		4,173,109	7,539,282	5.00

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

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

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

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

6.00	B	0.00	QUORUM HEALTH C	100.00	6.00
7.00	B	0.00	PASI	100.00	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: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet A-8-1 Date/Time Prepared: 4/30/2018 2:15 pm
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	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	0	0	1.00
2.00	0	0	2.00
3.00	-4,606,454	0	3.00
4.00	122,940	9	4.00
4.01	30,372	9	4.01
4.02	1,015,800	0	4.02
4.03	-2,768,007	0	4.03
4.04	0	0	4.04
4.05	0	0	4.05
4.06	2,839,176	0	4.06
5.00	-3,366,173		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	COLLECTION AGENCY	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: 14-0084

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

Worksheet A-8-2

Date/Time Prepared:
4/30/2018 2:15 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	25,448	25,448	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	95,334	82,409	12,925	177,200	103	2.00
3.00	30.00	ADULTS & PEDIATRICS	2,465,969	2,465,969	0	0	0	3.00
4.00	31.00	INTENSIVE CARE UNIT	232,750	232,750	0	0	0	4.00
5.00	50.00	OPERATING ROOM	1,068,676	1,068,676	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	1,125,000	1,125,000	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	21,431	21,431	0	0	0	7.00
8.00	60.00	LABORATORY	6,638	6,638	0	0	0	8.00
9.00	65.00	RESPIRATORY THERAPY	6,800	6,800	0	0	0	9.00
10.00	69.00	ELECTROCARDIOLOGY	180,001	180,001	0	0	0	10.00
11.00	91.00	EMERGENCY	3,075,557	3,075,557	0	0	0	11.00
200.00			8,303,604	8,290,679	12,925		103	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	13.00	NURSING ADMINISTRATION	8,775	439	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	7.00
8.00	60.00	LABORATORY	0	0	0	0	0	8.00
9.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	9.00
10.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	10.00
11.00	91.00	EMERGENCY	0	0	0	0	0	11.00
200.00			8,775	439	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	25,448		1.00
2.00	13.00	NURSING ADMINISTRATION	0	8,775	4,150	86,559		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,465,969		3.00
4.00	31.00	INTENSIVE CARE UNIT	0	0	0	232,750		4.00
5.00	50.00	OPERATING ROOM	0	0	0	1,068,676		5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	1,125,000		6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	21,431		7.00
8.00	60.00	LABORATORY	0	0	0	6,638		8.00
9.00	65.00	RESPIRATORY THERAPY	0	0	0	6,800		9.00
10.00	69.00	ELECTROCARDIOLOGY	0	0	0	180,001		10.00
11.00	91.00	EMERGENCY	0	0	0	3,075,557		11.00
200.00			0	8,775	4,150	8,294,829		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0084

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

Worksheet B
Part I
Date/Time Prepared:
4/30/2018 2:15 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	3,419,337	3,419,337			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	6,356,053		6,356,053		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	7,334,449	56,544	102,641	7,493,634	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	20,740,683	308,902	775,548	657,316	5.00
7.00 00700	OPERATION OF PLANT	4,516,153	945,647	1,880,339	135,171	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	624,381	63,376	115,043	0	8.00
9.00 00900	HOUSEKEEPING	1,438,021	34,659	62,914	0	9.00
10.00 01000	DIETARY	2,710,495	112,190	203,651	0	10.00
13.00 01300	NURSING ADMINISTRATION	3,702,942	19,024	34,533	447,453	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	914,980	86,273	156,606	57,946	14.00
15.00 01500	PHARMACY	2,134,029	25,373	46,058	232,314	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,185,310	40,306	73,164	139,960	16.00
17.00 01700	SOCIAL SERVICE	0	3,307	6,002	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	13,053,803	580,927	1,054,514	1,618,768	30.00
31.00 03100	INTENSIVE CARE UNIT	4,504,883	59,489	188,604	495,651	31.00
40.00 04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	41.00
43.00 04300	NURSERY	1,311,578	18,987	34,465	135,962	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	5,410,034	203,590	369,562	417,042	50.00
51.00 05100	RECOVERY ROOM	1,662,416	24,928	45,250	216,600	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	2,077,899	64,501	117,084	214,081	52.00
53.00 05300	ANESTHESIOLOGY	296,532	6,802	12,347	5,348	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	7,948,089	191,624	357,790	698,640	54.00
54.01 05401	ULTRASOUND	0	0	0	0	54.01
56.00 05600	RADIOISOTOPE	0	0	0	0	56.00
57.00 05700	CT SCAN	-74,448	0	0	0	57.00
58.00 05800	MRI	0	0	0	0	58.00
60.00 06000	LABORATORY	7,109,722	81,427	147,808	473,498	60.00
65.00 06500	RESPIRATORY THERAPY	1,258,591	27,306	49,566	140,634	65.00
66.00 06600	PHYSICAL THERAPY	3,091,657	81,102	147,219	370,470	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	2,642,204	41,778	75,850	255,868	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,305,843	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	5,270,099	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	4,939,550	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	948,157	0	0	0	74.00
76.00 03020	CARDIAC REHAB	0	0	0	0	76.00
76.02 03951	GUI DANCE	155,618	0	0	16,634	76.02
76.03 03952	WOUND CARE	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
91.00 09100	EMERGENCY	6,289,312	163,458	296,713	671,686	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	191,516	0	0	36,746	95.00
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00 11600	HOSPICE	0	0	0	0	116.00
118.00 11800	SUBTOTALS (SUM OF LINES 1 through 117)	127,469,888	3,241,520	6,353,271	7,437,788	118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	11,887	0	0	6,701	192.00
194.00 07950	CLINIC CORPORATION	0	0	0	0	194.00
194.01 07951	SENIOR CIRCLE	0	1,533	2,782	0	194.01
194.02 07952	MARKETING	769,084	1,533	0	34,118	194.02
194.03 07953	VISTA MEDICAL CENTER WEST	105,917	0	0	15,027	194.03
194.04 07954	ABBOTT RESEARCH	0	174,751	0	0	194.04
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	TOTAL (sum lines 118 through 201)	128,356,776	3,419,337	6,356,053	7,493,634	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0084

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

Worksheet B
Part I
Date/Time Prepared:
4/30/2018 2:15 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	22,482,449				5.00
7.00	00700	OPERATION OF PLANT	1,586,693	9,064,003			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	170,355	272,475	1,245,630		8.00
9.00	00900	HOUSEKEEPING	325,855	149,009	0	2,010,458	9.00
10.00	01000	DIETARY	642,192	482,342	0	119,732	4,270,602
13.00	01300	NURSING ADMINISTRATION	892,083	81,791	0	20,303	0
14.00	01400	CENTRAL SERVICES & SUPPLY	257,995	370,917	34,287	92,073	0
15.00	01500	PHARMACY	517,298	109,088	0	27,079	0
16.00	01600	MEDICAL RECORDS & LIBRARY	517,503	173,287	0	43,015	0
17.00	01700	SOCIAL SERVICE	1,975	14,216	0	3,529	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,460,589	2,497,589	507,521	619,977	3,686,769
31.00	03100	INTENSIVE CARE UNIT	1,113,764	255,760	105,264	110,886	363,340
40.00	04000	SUBPROVIDER - I PF	0	0	0	0	0
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0
43.00	04300	NURSERY	318,512	81,629	13,059	20,263	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,358,135	875,297	113,735	217,275	292
51.00	05100	RECOVERY ROOM	413,621	107,173	49,709	26,604	1,497
52.00	05200	DELIVERY ROOM & LABOR ROOM	524,893	277,311	111,501	68,837	88,343
53.00	05300	ANESTHESIOLOGY	68,123	29,244	0	7,259	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,951,431	823,853	93,034	210,355	13,945
54.01	05401	ULTRASOUND	0	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MRI	0	0	0	0	0
60.00	06000	LABORATORY	1,657,811	350,080	0	86,900	0
65.00	06500	RESPIRATORY THERAPY	313,229	117,396	3,233	29,141	0
66.00	06600	PHYSICAL THERAPY	783,117	348,684	279	86,554	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	639,935	179,616	22,843	44,594	21,538
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	701,503	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,118,320	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,048,177	0	0	0	0
74.00	07400	RENAL DIALYSIS	201,200	0	0	0	0
76.00	03020	CARDIAC REHAB	0	0	0	0	0
76.02	03951	GUI DANCE	36,552	0	0	0	0
76.03	03952	WOUND CARE	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	1,574,779	702,756	191,165	174,446	94,878
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	48,437	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,244,077	8,299,513	1,245,630	2,008,822	4,270,602
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,944	0	0	0	0
194.00	07950	CLINIC CORPORATION	0	0	0	0	0
194.01	07951	SENIOR CIRCLE	916	6,589	0	1,636	0
194.02	07952	MARKETING	170,766	6,589	0	0	0
194.03	07953	VISTA MEDICAL CENTER WEST	25,664	0	0	0	0
194.04	07954	ABBOTT RESEARCH	37,082	751,312	0	0	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	22,482,449	9,064,003	1,245,630	2,010,458	4,270,602

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 14-0084		Period: From 12/01/2016 To 11/30/2017		Worksheet B Part I Date/Time Prepared: 4/30/2018 2:15 pm	
Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION	5,198,129					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,971,077				14.00
15.00	01500	PHARMACY	0	19,032	3,110,271			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,234	0	3,173,779		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	29,029	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,245,542	104,686	0	306,882	23,805	30.00
31.00	03100	INTENSIVE CARE UNIT	687,571	59,553	0	63,804	3,030	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	188,607	12,577	0	17,394	2,194	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	578,524	244,869	0	598,167	0	50.00
51.00	05100	RECOVERY ROOM	300,469	3,075	0	58,038	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	296,975	31,946	0	27,388	0	52.00
53.00	05300	ANESTHESIOLOGY	7,419	32,701	0	17,679	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	59,197	0	603,632	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	126,356	0	304,587	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	24,913	0	61,835	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,081	0	64,128	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	47,645	0	176,513	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	424,895	0	28,057	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	677,015	0	94,073	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,110,271	358,196	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	15,571	0	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.02	03951	GUI DANCE	23,075	94	0	1,145	0	76.02
76.03	03952	WOUND CARE	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	869,947	88,482	0	376,690	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	6,535	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,198,129	1,966,886	3,110,271	3,173,779	29,029	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CLINIC CORPORATION	0	0	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	0	3,874	0	0	0	194.01
194.02	07952	MARKETING	0	317	0	0	0	194.02
194.03	07953	VISTA MEDICAL CENTER WEST	0	0	0	0	0	194.03
194.04	07954	ABBOTT RESEARCH	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,198,129	1,971,077	3,110,271	3,173,779	29,029	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0084

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

Worksheet B
Part I
Date/Time Prepared:
4/30/2018 2:15 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,761,372	0	29,761,372	30.00
31.00	03100	INTENSIVE CARE UNIT	8,011,599	0	8,011,599	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	41.00
43.00	04300	NURSERY	2,155,227	0	2,155,227	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,386,522	0	10,386,522	50.00
51.00	05100	RECOVERY ROOM	2,909,380	0	2,909,380	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,900,759	0	3,900,759	52.00
53.00	05300	ANESTHESIOLOGY	483,454	0	483,454	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,951,590	0	12,951,590	54.00
54.01	05401	ULTRASOUND	0	0	0	54.01
56.00	05600	RADIOLOGY-SOFT	0	0	0	56.00
57.00	05700	CT SCAN	-74,448	0	-74,448	57.00
58.00	05800	MRI	0	0	0	58.00
60.00	06000	LABORATORY	10,338,189	0	10,338,189	60.00
65.00	06500	RESPIRATORY THERAPY	2,025,844	0	2,025,844	65.00
66.00	06600	PHYSICAL THERAPY	4,975,291	0	4,975,291	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,148,384	0	4,148,384	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,460,298	0	4,460,298	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,159,507	0	7,159,507	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,456,194	0	9,456,194	73.00
74.00	07400	RENAL DIALYSIS	1,164,928	0	1,164,928	74.00
76.00	03020	CARDIAC REHAB	0	0	0	76.00
76.02	03951	GUI DANCE	233,118	0	233,118	76.02
76.03	03952	WOUND CARE	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
91.00	09100	EMERGENCY	11,494,312	0	11,494,312	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	283,234	0	283,234	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	126,224,754	0	126,224,754	118.00
NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	22,532	0	22,532	192.00
194.00	07950	CLINIC CORPORATION	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	17,330	0	17,330	194.01
194.02	07952	MARKETING	982,407	0	982,407	194.02
194.03	07953	VISTA MEDICAL CENTER WEST	146,608	0	146,608	194.03
194.04	07954	ABBOTT RESEARCH	963,145	0	963,145	194.04
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	128,356,776	0	128,356,776	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet B Part II Date/Time Prepared: 4/30/2018 2:15 pm
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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			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	56,544	102,641	159,185	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	308,902	775,548	1,084,450	5.00
7.00 00700	OPERATION OF PLANT	0	945,647	1,880,339	2,825,986	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	63,376	115,043	178,419	8.00
9.00 00900	HOUSEKEEPING	0	34,659	62,914	97,573	9.00
10.00 01000	DIETARY	0	112,190	203,651	315,841	10.00
13.00 01300	NURSING ADMINISTRATION	0	19,024	34,533	53,557	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	86,273	156,606	242,879	14.00
15.00 01500	PHARMACY	0	25,373	46,058	71,431	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	40,306	73,164	113,470	16.00
17.00 01700	SOCIAL SERVICE	0	3,307	6,002	9,309	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	580,927	1,054,514	1,635,441	30.00
31.00 03100	INTENSIVE CARE UNIT	0	59,489	188,604	248,093	31.00
40.00 04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	41.00
43.00 04300	NURSERY	0	18,987	34,465	53,452	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	203,590	369,562	573,152	50.00
51.00 05100	RECOVERY ROOM	0	24,928	45,250	70,178	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	64,501	117,084	181,585	52.00
53.00 05300	ANESTHESIOLOGY	0	6,802	12,347	19,149	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	191,624	357,790	549,414	54.00
54.01 05401	ULTRASOUND	0	0	0	0	54.01
56.00 05600	RADIOLOGY	0	0	0	0	56.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MRI	0	0	0	0	58.00
60.00 06000	LABORATORY	0	81,427	147,808	229,235	60.00
65.00 06500	RESPIRATORY THERAPY	0	27,306	49,566	76,872	65.00
66.00 06600	PHYSICAL THERAPY	0	81,102	147,219	228,321	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	41,778	75,850	117,628	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00 03020	CARDIAC REHAB	0	0	0	0	76.00
76.02 03951	GUIDANCE	0	0	0	0	76.02
76.03 03952	WOUND CARE	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
91.00 09100	EMERGENCY	0	163,458	296,713	460,171	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00 11600	HOSPICE	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	3,241,520	6,353,271	9,594,791	118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	CLINIC CORPORATION	0	0	0	0	194.00
194.01 07951	SENIOR CIRCLE	0	1,533	2,782	4,315	194.01
194.02 07952	MARKETING	0	1,533	0	1,533	194.02
194.03 07953	VISTA MEDICAL CENTER WEST	0	0	0	0	194.03
194.04 07954	ABBOTT RESEARCH	0	174,751	0	174,751	194.04
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	3,419,337	6,356,053	9,775,390	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet B Part II Date/Time Prepared: 4/30/2018 2:15 pm		
Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
			5.00	7.00	8.00	9.00	10.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,098,414				5.00
7.00	00700	OPERATION OF PLANT	77,517	2,906,375			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,323	87,369	274,111		8.00
9.00	00900	HOUSEKEEPING	15,920	47,780	0	161,273	9.00
10.00	01000	DIETARY	31,374	154,663	0	9,605	511,483
13.00	01300	NURSING ADMINISTRATION	43,582	26,226	0	1,629	0
14.00	01400	CENTRAL SERVICES & SUPPLY	12,604	118,935	7,545	7,386	0
15.00	01500	PHARMACY	25,272	34,979	0	2,172	0
16.00	01600	MEDICAL RECORDS & LIBRARY	25,282	55,565	0	3,451	0
17.00	01700	SOCIAL SERVICE	97	4,558	0	283	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	169,107	800,852	111,684	49,732	441,558
31.00	03100	INTENSIVE CARE UNIT	54,413	82,010	23,164	8,895	43,517
40.00	04000	SUBPROVIDER - I/PF	0	0	0	0	0
41.00	04100	SUBPROVIDER - I/RF	0	0	0	0	0
43.00	04300	NURSERY	15,561	26,174	2,874	1,625	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	66,351	280,664	25,028	17,429	35
51.00	05100	RECOVERY ROOM	20,207	34,365	10,939	2,134	179
52.00	05200	DELIVERY ROOM & LABOR ROOM	25,643	88,920	24,537	5,522	10,581
53.00	05300	ANESTHESIOLOGY	3,328	9,377	0	582	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	95,336	264,169	20,473	16,874	1,670
54.01	05401	ULTRASOUND	0	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MRI	0	0	0	0	0
60.00	06000	LABORATORY	80,992	112,253	0	6,971	0
65.00	06500	RESPIRATORY THERAPY	15,303	37,643	712	2,338	0
66.00	06600	PHYSICAL THERAPY	38,259	111,806	61	6,943	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	31,264	57,594	5,027	3,577	2,580
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	34,272	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	54,635	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	51,208	0	0	0	0
74.00	07400	RENAL DIALYSIS	9,830	0	0	0	0
76.00	03020	CARDIAC REHAB	0	0	0	0	0
76.02	03951	GUI DANCE	1,786	0	0	0	0
76.03	03952	WOUND CARE	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	76,935	225,339	42,067	13,994	11,363
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	2,366	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,086,767	2,661,241	274,111	161,142	511,483
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	193	0	0	0	0
194.00	07950	CLINIC CORPORATION	0	0	0	0	0
194.01	07951	SENIOR CIRCLE	45	2,113	0	131	0
194.02	07952	MARKETING	8,343	2,113	0	0	0
194.03	07953	VISTA MEDICAL CENTER WEST	1,254	0	0	0	0
194.04	07954	ABBOTT RESEARCH	1,812	240,908	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	1,098,414	2,906,375	274,111	161,273	511,483

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet B Part II Date/Time Prepared: 4/30/2018 2:15 pm		
Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE
		13.00	14.00	15.00	16.00	17.00
GENERAL SERVICE COST CENTERS						
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	134,500				13.00
14.00	01400	0	390,580			14.00
15.00	01500	0	3,771	142,560		15.00
16.00	01600	0	245	0	200,986	16.00
17.00	01700	0	0	0	0	14,247
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	58,107	20,744	0	19,414	11,683
31.00	03100	17,790	11,801	0	4,036	1,487
40.00	04000	0	0	0	0	0
41.00	04100	0	0	0	0	0
43.00	04300	4,880	2,492	0	1,100	1,077
ANCILLARY SERVICE COST CENTERS						
50.00	05000	14,968	48,522	0	37,841	0
51.00	05100	7,774	609	0	3,672	0
52.00	05200	7,684	6,330	0	1,733	0
53.00	05300	192	6,480	0	1,118	0
54.00	05400	0	11,730	0	38,395	0
54.01	05401	0	0	0	0	0
56.00	05600	0	0	0	0	0
57.00	05700	0	0	0	0	0
58.00	05800	0	0	0	0	0
60.00	06000	0	25,038	0	19,269	0
65.00	06500	0	4,936	0	3,912	0
66.00	06600	0	412	0	4,057	0
67.00	06700	0	0	0	0	0
68.00	06800	0	0	0	0	0
69.00	06900	0	9,441	0	11,166	0
71.00	07100	0	84,194	0	1,775	0
72.00	07200	0	134,157	0	5,951	0
73.00	07300	0	0	142,560	22,660	0
74.00	07400	0	0	0	985	0
76.00	03020	0	0	0	0	0
76.02	03951	597	19	0	72	0
76.03	03952	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	0	0	0	0	0
91.00	09100	22,508	17,533	0	23,830	0
92.00	09200					
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	0	1,295	0	0	0
101.00	10100	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
116.00	11600	0	0	0	0	0
118.00		134,500	389,749	142,560	200,986	14,247
NONREIMBURSABLE COST CENTERS						
192.00	19200	0	0	0	0	0
194.00	07950	0	0	0	0	0
194.01	07951	0	768	0	0	0
194.02	07952	0	63	0	0	0
194.03	07953	0	0	0	0	0
194.04	07954	0	0	0	0	0
200.00						
201.00		0	0	0	0	0
202.00		134,500	390,580	142,560	200,986	14,247

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet B Part II Date/Time Prepared: 4/30/2018 2:15 pm
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	3,352,699	0	3,352,699
31.00	03100	INTENSIVE CARE UNIT	505,736	0	505,736
40.00	04000	SUBPROVIDER - IPF	0	0	0
41.00	04100	SUBPROVIDER - IRF	0	0	0
43.00	04300	NURSERY	112,123	0	112,123
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,072,850	0	1,072,850
51.00	05100	RECOVERY ROOM	154,659	0	154,659
52.00	05200	DELIVERY ROOM & LABOR ROOM	357,083	0	357,083
53.00	05300	ANESTHESIOLOGY	40,340	0	40,340
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,012,903	0	1,012,903
54.01	05401	ULTRASOUND	0	0	0
56.00	05600	RADIOLOGY-SOFT	0	0	0
57.00	05700	CT SCAN	0	0	0
58.00	05800	MRI	0	0	0
60.00	06000	LABORATORY	483,817	0	483,817
65.00	06500	RESPIRATORY THERAPY	144,704	0	144,704
66.00	06600	PHYSICAL THERAPY	397,729	0	397,729
67.00	06700	OCCUPATIONAL THERAPY	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0
69.00	06900	ELECTROCARDIOLOGY	243,713	0	243,713
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	120,241	0	120,241
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	194,743	0	194,743
73.00	07300	DRUGS CHARGED TO PATIENTS	216,428	0	216,428
74.00	07400	RENAL DIALYSIS	10,815	0	10,815
76.00	03020	CARDIAC REHAB	0	0	0
76.02	03951	GUI DANCE	2,827	0	2,827
76.03	03952	WOUND CARE	0	0	0
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0
91.00	09100	EMERGENCY	908,010	0	908,010
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	4,442	0	4,442
101.00	10100	HOME HEALTH AGENCY	0	0	0
SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,335,862	0	9,335,862
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	335	0	335
194.00	07950	CLINIC CORPORATION	0	0	0
194.01	07951	SENIOR CIRCLE	7,372	0	7,372
194.02	07952	MARKETING	12,777	0	12,777
194.03	07953	VISTA MEDICAL CENTER WEST	1,573	0	1,573
194.04	07954	ABBOTT RESEARCH	417,471	0	417,471
200.00		Cross Foot Adjustments	0	0	0
201.00		Negative Cost Centers	0	0	0
202.00		TOTAL (sum lines 118 through 201)	9,775,390	0	9,775,390

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0084

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

Worksheet B-1
Date/Time Prepared:
4/30/2018 2:15 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)		
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00	5A	5.00		
GENERAL SERVICE COST CENTERS							
1.00 00100 CAP REL COSTS-BLDG & FIXT	452,934					1.00	
2.00 00200 CAP REL COSTS-MVBLE EQUIP		463,820				2.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	7,490	7,490	52,819,550			4.00	
5.00 00500 ADMINISTRATIVE & GENERAL	40,918	56,594	4,633,160	-22,482,449	105,948,775	5.00	
7.00 00700 OPERATION OF PLANT	125,263	137,214	952,770	0	7,477,310	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	8,395	8,395	0	0	802,800	8.00	
9.00 00900 HOUSEKEEPING	4,591	4,591	0	0	1,535,594	9.00	
10.00 01000 DIETARY	14,861	14,861	0	0	3,026,336	10.00	
13.00 01300 NURSING ADMINISTRATION	2,520	2,520	3,153,920	0	4,203,952	13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	11,428	11,428	408,438	0	1,215,805	14.00	
15.00 01500 PHARMACY	3,361	3,361	1,637,490	0	2,437,774	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	5,339	5,339	986,521	0	2,438,740	16.00	
17.00 01700 SOCIAL SERVICE	438	438	0	0	9,309	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	76,951	76,951	11,409,932	0	16,308,012	30.00	
31.00 03100 INTENSIVE CARE UNIT	7,880	13,763	3,493,651	0	5,248,627	31.00	
40.00 04000 SUBPROVIDER - I/PF	0	0	0	0	0	40.00	
41.00 04100 SUBPROVIDER - I/RF	0	0	0	0	0	41.00	
43.00 04300 NURSERY	2,515	2,515	958,342	0	1,500,992	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	26,968	26,968	2,939,565	0	6,400,228	50.00	
51.00 05100 RECOVERY ROOM	3,302	3,302	1,526,727	0	1,949,194	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	8,544	8,544	1,508,973	0	2,473,565	52.00	
53.00 05300 ANESTHESIOLOGY	901	901	37,696	0	321,029	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	25,383	26,109	4,924,441	0	9,196,143	54.00	
54.01 05401 ULTRASOUND	0	0	0	0	0	54.01	
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00	
57.00 05700 CT SCAN	0	0	0	74,448	0	57.00	
58.00 05800 MRI	0	0	0	0	0	58.00	
60.00 06000 LABORATORY	10,786	10,786	3,337,503	0	7,812,455	60.00	
65.00 06500 RESPIRATORY THERAPY	3,617	3,617	991,274	0	1,476,097	65.00	
66.00 06600 PHYSICAL THERAPY	10,743	10,743	2,611,298	0	3,690,448	66.00	
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00 06900 ELECTROCARDIOLOGY	5,534	5,535	1,803,514	0	3,015,700	69.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	3,305,843	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	5,270,099	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	4,939,550	73.00	
74.00 07400 RENAL DIALYSIS	0	0	0	0	948,157	74.00	
76.00 03020 CARDIAC REHAB	0	0	0	0	0	76.00	
76.02 03951 GUI DANCE	0	0	117,246	0	172,252	76.02	
76.03 03952 WOUND CARE	0	0	0	0	0	76.03	
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00	
91.00 09100 EMERGENCY	21,652	21,652	4,734,448	0	7,421,169	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00	
OTHER REIMBURSABLE COST CENTERS							
95.00 09500 AMBULANCE SERVICES	0	0	259,007	0	228,262	95.00	
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00	
SPECIAL PURPOSE COST CENTERS							
116.00 11600 HOSPICE	0	0	0	0	0	116.00	
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	429,380	463,617	52,425,916	-22,408,001	104,825,442	118.00
NONREIMBURSABLE COST CENTERS							
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	47,233	0	18,588	192.00	
194.00 07950 CLINIC CORPORATION	0	0	0	0	0	194.00	
194.01 07951 SENIOR CIRCLE	203	203	0	0	4,315	194.01	
194.02 07952 MARKETING	203	0	240,484	0	804,735	194.02	
194.03 07953 VISTA MEDICAL CENTER WEST	0	0	105,917	0	120,944	194.03	
194.04 07954 ABBOTT RESEARCH	23,148	0	0	0	174,751	194.04	
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)	3,419,337	6,356,053	7,493,634	22,482,449	202.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	7.549305	13.703706	0.141872	0.212201	203.00	
204.00	Cost to be allocated (per Wkst. B, Part II)			159,185	1,098,414	204.00	
205.00	Unit cost multiplier (Wkst. B, Part II)			0.003014	0.010367	205.00	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0084

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

Worksheet B-1

Date/Time Prepared:
4/30/2018 2:15 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				
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: 14-0084

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

Worksheet B-1

Date/Time Prepared:
4/30/2018 2:15 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		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT	279,263				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	8,395	1,277,808			8.00	
9.00	00900	HOUSEKEEPING	4,591	0	249,536		9.00	
10.00	01000	DIETARY	14,861	0	14,861	116,985	10.00	
13.00	01300	NURSING ADMINISTRATION	2,520	0	2,520	26,412,461	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	11,428	35,173	11,428	0	14.00	
15.00	01500	PHARMACY	3,361	0	3,361	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	5,339	0	5,339	0	16.00	
17.00	01700	SOCIAL SERVICE	438	0	438	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	76,951	520,633	76,951	100,992	11,409,932	30.00
31.00	03100	INTENSIVE CARE UNIT	7,880	107,983	13,763	9,953	3,493,651	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	2,515	13,396	2,515	0	958,342	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	26,968	116,673	26,968	8	2,939,565	50.00
51.00	05100	RECOVERY ROOM	3,302	50,993	3,302	41	1,526,727	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,544	114,381	8,544	2,420	1,508,973	52.00
53.00	05300	ANESTHESIOLOGY	901	0	901	0	37,696	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,383	95,437	26,109	382	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOLOGY	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	10,786	0	10,786	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,617	3,317	3,617	0	0	65.00
66.00	06600	PHYSICAL THERAPY	10,743	286	10,743	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,534	23,433	5,535	590	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.02	03951	GUI DANCE	0	0	0	0	117,246	76.02
76.03	03952	WOUND CARE	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	21,652	196,103	21,652	2,599	4,420,329	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	255,709	1,277,808	249,333	116,985	26,412,461	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CLINIC CORPORATION	0	0	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	203	0	203	0	0	194.01
194.02	07952	MARKETING	203	0	0	0	0	194.02
194.03	07953	VISTA MEDICAL CENTER WEST	0	0	0	0	0	194.03
194.04	07954	ABBOTT RESEARCH	23,148	0	0	0	0	194.04
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)	9,064,003	1,245,630	2,010,458	4,270,602	5,198,129	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	32.456870	0.974818	8.056785	36.505552	0.196806	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,906,375	274,111	161,273	511,483	134,500	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	10.407304	0.214517	0.646292	4.372210	0.005092	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0084

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

Worksheet B-1

Date/Time Prepared:
4/30/2018 2:15 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	
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 14-0084		Period: From 12/01/2016 To 11/30/2017		Worksheet B-1	
Cost Center Description		CENTRAL SERVICES & SUPPLY (TOTAL SUPPLIE)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PT. DAYS & OP OB)		
		14.00	15.00	16.00	17.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14,812,480				14.00
15.00	01500	PHARMACY	143,021	4,940,037			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,277	0	1,247,075,972		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	47,023	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	786,701	0	120,582,338	38,561	30.00
31.00	03100	INTENSIVE CARE UNIT	447,538	0	25,070,412	4,908	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
43.00	04300	NURSERY	94,514	0	6,834,393	3,554	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,840,167	0	235,036,117	0	50.00
51.00	05100	RECOVERY ROOM	23,109	0	22,804,665	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	240,072	0	10,761,648	0	52.00
53.00	05300	ANESTHESIOLOGY	245,747	0	6,946,415	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	444,861	0	237,195,031	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	949,551	0	119,680,610	0	60.00
65.00	06500	RESPIRATORY THERAPY	187,215	0	24,296,774	0	65.00
66.00	06600	PHYSICAL THERAPY	15,642	0	25,197,567	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	358,051	0	69,356,745	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,193,041	0	11,024,329	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,087,739	0	36,964,010	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,940,037	140,744,984	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	6,118,080	0	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	76.00
76.02	03951	GUIDANCE	703	0	449,988	0	76.02
76.03	03952	WOUND CARE	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
91.00	09100	EMERGENCY	664,931	0	148,011,866	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	49,107	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,780,987	4,940,037	1,247,075,972	47,023	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	CLINIC CORPORATION	0	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	29,109	0	0	0	194.01
194.02	07952	MARKETING	2,384	0	0	0	194.02
194.03	07953	VISTA MEDICAL CENTER WEST	0	0	0	0	194.03
194.04	07954	ABBOTT RESEARCH	0	0	0	0	194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,971,077	3,110,271	3,173,779	29,029	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.133069	0.629605	0.002545	0.617336	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	390,580	142,560	200,986	14,247	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.026368	0.028858	0.000161	0.302979	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0084

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

Worksheet B-1

Date/Time Prepared:
4/30/2018 2:15 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (TOTAL SUPPLIE)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PT. DAYS & OP OB)		
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)	14.00	15.00	16.00	17.00		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet C Part I Date/Time Prepared: 4/30/2018 2:15 pm
			Title XVIII	Hospital	PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
			Total Costs	RCE Disallowance	Total Costs
	1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		29,761,372	0	29,761,372
31.00	03100 INTENSIVE CARE UNIT		8,011,599	0	8,011,599
40.00	04000 SUBPROVIDER - I PF		0	0	0
41.00	04100 SUBPROVIDER - I RF		0	0	0
43.00	04300 NURSERY		2,155,227	0	2,155,227
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM		10,386,522	0	10,386,522
51.00	05100 RECOVERY ROOM		2,909,380	0	2,909,380
52.00	05200 DELIVERY ROOM & LABOR ROOM		3,900,759	0	3,900,759
53.00	05300 ANESTHESIOLOGY		483,454	0	483,454
54.00	05400 RADIOLOGY-DIAGNOSTIC		12,951,590	0	12,951,590
54.01	05401 ULTRASOUND		0	0	0
56.00	05600 RADIOLOGY		0	0	0
57.00	05700 CT SCAN		0	0	0
58.00	05800 MRI		0	0	0
60.00	06000 LABORATORY		10,338,189	0	10,338,189
65.00	06500 RESPIRATORY THERAPY	0	2,025,844	0	2,025,844
66.00	06600 PHYSICAL THERAPY	0	4,975,291	0	4,975,291
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0
68.00	06800 SPEECH PATHOLOGY	0	0	0	0
69.00	06900 ELECTROCARDIOLOGY		4,148,384	0	4,148,384
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		4,460,298	0	4,460,298
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		7,159,507	0	7,159,507
73.00	07300 DRUGS CHARGED TO PATIENTS		9,456,194	0	9,456,194
74.00	07400 RENAL DIALYSIS		1,164,928	0	1,164,928
76.00	03020 CARDIAC REHAB		0	0	0
76.02	03951 GUIDANCE		233,118	0	233,118
76.03	03952 WOUND CARE		0	0	0
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC		0	0	0
91.00	09100 EMERGENCY		11,494,312	0	11,494,312
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		2,223,758	0	2,223,758
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES		283,234	0	283,234
101.00	10100 HOME HEALTH AGENCY		0	0	0
SPECIAL PURPOSE COST CENTERS					
116.00	11600 HOSPICE		0	0	0
200.00	Subtotal (see instructions)		128,522,960	0	128,522,960
201.00	Less Observation Beds		2,223,758	0	2,223,758
202.00	Total (see instructions)		126,299,202	0	126,299,202

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0084		Period: From 12/01/2016 To 11/30/2017		Worksheet C Part I Date/Time Prepared: 4/30/2018 2:15 pm		
			Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	110,468,070		110,468,070				30.00
31.00	03100	INTENSIVE CARE UNIT	25,070,412		25,070,412				31.00
40.00	04000	SUBPROVIDER - IPF	0		0				40.00
41.00	04100	SUBPROVIDER - IRF	0		0				41.00
43.00	04300	NURSERY	6,834,393		6,834,393				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	132,412,761	102,623,356	235,036,117	0.044191	0.000000		50.00
51.00	05100	RECOVERY ROOM	9,730,955	13,073,710	22,804,665	0.127578	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,369,071	1,392,577	10,761,648	0.362469	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	4,278,161	2,668,254	6,946,415	0.069598	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	66,665,125	170,529,906	237,195,031	0.054603	0.000000		54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000		54.01
56.00	05600	RADIOLOGY	0	0	0	0.000000	0.000000		56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000		57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000		58.00
60.00	06000	LABORATORY	65,513,660	54,166,950	119,680,610	0.086381	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	21,918,041	2,378,733	24,296,774	0.083379	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	10,821,005	14,376,562	25,197,567	0.197451	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	43,898,436	25,458,309	69,356,745	0.059812	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,689,077	4,335,252	11,024,329	0.404587	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,753,085	11,210,925	36,964,010	0.193689	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	105,663,649	35,081,335	140,744,984	0.067187	0.000000		73.00
74.00	07400	RENAL DIALYSIS	5,985,302	132,778	6,118,080	0.190407	0.000000		74.00
76.00	03020	CARDIAC REHAB	0	0	0	0.000000	0.000000		76.00
76.02	03951	GUI DANCE	78,138	371,850	449,988	0.518054	0.000000		76.02
76.03	03952	WOUND CARE	0	0	0	0.000000	0.000000		76.03
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0				88.00
91.00	09100	EMERGENCY	40,096,735	107,915,131	148,011,866	0.077658	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,500,354	6,613,914	10,114,268	0.219863	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0				101.00
SPECIAL PURPOSE COST CENTERS									
116.00	11600	HOSPICE	0	0	0				116.00
200.00		Subtotal (see instructions)	694,746,430	552,329,542	1,247,075,972				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	694,746,430	552,329,542	1,247,075,972				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet C Part I Date/Time Prepared: 4/30/2018 2:15 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.044191		50.00
51.00	05100 RECOVERY ROOM	0.127578		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.362469		52.00
53.00	05300 ANESTHESIOLOGY	0.069598		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.054603		54.00
54.01	05401 ULTRASOUND	0.000000		54.01
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
60.00	06000 LABORATORY	0.086381		60.00
65.00	06500 RESPIRATORY THERAPY	0.083379		65.00
66.00	06600 PHYSICAL THERAPY	0.197451		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.059812		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.404587		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.193689		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.067187		73.00
74.00	07400 RENAL DIALYSIS	0.190407		74.00
76.00	03020 CARDIAC REHAB	0.000000		76.00
76.02	03951 GUIDANCE	0.518054		76.02
76.03	03952 WOUND CARE	0.000000		76.03
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC			88.00
91.00	09100 EMERGENCY	0.077658		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.219863		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet C Part I Date/Time Prepared: 4/30/2018 2:15 pm
			Title XIX	Hospital	PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
			Total Costs	RCE Disallowance	Total Costs
	1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		29,761,372	0	29,761,372
31.00	03100 INTENSIVE CARE UNIT		8,011,599	0	8,011,599
40.00	04000 SUBPROVIDER - I PF		0	0	0
41.00	04100 SUBPROVIDER - I RF		0	0	0
43.00	04300 NURSERY		2,155,227	0	2,155,227
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM		10,386,522	0	10,386,522
51.00	05100 RECOVERY ROOM		2,909,380	0	2,909,380
52.00	05200 DELIVERY ROOM & LABOR ROOM		3,900,759	0	3,900,759
53.00	05300 ANESTHESIOLOGY		483,454	0	483,454
54.00	05400 RADIOLOGY-DIAGNOSTIC		12,951,590	0	12,951,590
54.01	05401 ULTRASOUND		0	0	0
56.00	05600 RADIOLOGY		0	0	0
57.00	05700 CT SCAN		0	0	0
58.00	05800 MRI		0	0	0
60.00	06000 LABORATORY		10,338,189	0	10,338,189
65.00	06500 RESPIRATORY THERAPY	0	2,025,844	0	2,025,844
66.00	06600 PHYSICAL THERAPY	0	4,975,291	0	4,975,291
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0
68.00	06800 SPEECH PATHOLOGY	0	0	0	0
69.00	06900 ELECTROCARDIOLOGY		4,148,384	0	4,148,384
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		4,460,298	0	4,460,298
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		7,159,507	0	7,159,507
73.00	07300 DRUGS CHARGED TO PATIENTS		9,456,194	0	9,456,194
74.00	07400 RENAL DIALYSIS		1,164,928	0	1,164,928
76.00	03020 CARDIAC REHAB		0	0	0
76.02	03951 GUIDANCE		233,118	0	233,118
76.03	03952 WOUND CARE		0	0	0
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC		0	0	0
91.00	09100 EMERGENCY		11,494,312	0	11,494,312
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		2,223,758	0	2,223,758
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES		283,234	0	283,234
101.00	10100 HOME HEALTH AGENCY		0	0	0
SPECIAL PURPOSE COST CENTERS					
116.00	11600 HOSPICE		0	0	0
200.00	Subtotal (see instructions)		128,522,960	0	128,522,960
201.00	Less Observation Beds		2,223,758	0	2,223,758
202.00	Total (see instructions)		126,299,202	0	126,299,202

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0084

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

Worksheet C
Part I
Date/Time Prepared:
4/30/2018 2:15 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
		9.00			10.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	110,468,070		110,468,070		30.00
31.00	03100	INTENSIVE CARE UNIT	25,070,412		25,070,412		31.00
40.00	04000	SUBPROVIDER - IPF	0		0		40.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
43.00	04300	NURSERY	6,834,393		6,834,393		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	132,412,761	102,623,356	235,036,117	0.044191	50.00
51.00	05100	RECOVERY ROOM	9,730,955	13,073,710	22,804,665	0.127578	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,369,071	1,392,577	10,761,648	0.362469	52.00
53.00	05300	ANESTHESIOLOGY	4,278,161	2,668,254	6,946,415	0.069598	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	66,665,125	170,529,906	237,195,031	0.054603	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	54.01
56.00	05600	RADIOLOGY	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	65,513,660	54,166,950	119,680,610	0.086381	60.00
65.00	06500	RESPIRATORY THERAPY	21,918,041	2,378,733	24,296,774	0.083379	65.00
66.00	06600	PHYSICAL THERAPY	10,821,005	14,376,562	25,197,567	0.197451	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	43,898,436	25,458,309	69,356,745	0.059812	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,689,077	4,335,252	11,024,329	0.404587	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,753,085	11,210,925	36,964,010	0.193689	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	105,663,649	35,081,335	140,744,984	0.067187	73.00
74.00	07400	RENAL DIALYSIS	5,985,302	132,778	6,118,080	0.190407	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0.000000	76.00
76.02	03951	GUI DANCE	78,138	371,850	449,988	0.518054	76.02
76.03	03952	WOUND CARE	0	0	0	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	88.00
91.00	09100	EMERGENCY	40,096,735	107,915,131	148,011,866	0.077658	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,500,354	6,613,914	10,114,268	0.219863	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0.000000	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0		116.00
200.00		Subtotal (see instructions)	694,746,430	552,329,542	1,247,075,972		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	694,746,430	552,329,542	1,247,075,972		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet C Part I Date/Time Prepared: 4/30/2018 2:15 pm
		Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.044191		50.00
51.00	05100 RECOVERY ROOM	0.127578		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.362469		52.00
53.00	05300 ANESTHESIOLOGY	0.069598		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.054603		54.00
54.01	05401 ULTRASOUND	0.000000		54.01
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
60.00	06000 LABORATORY	0.086381		60.00
65.00	06500 RESPIRATORY THERAPY	0.083379		65.00
66.00	06600 PHYSICAL THERAPY	0.197451		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.059812		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.404587		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.193689		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.067187		73.00
74.00	07400 RENAL DIALYSIS	0.190407		74.00
76.00	03020 CARDIAC REHAB	0.000000		76.00
76.02	03951 GUIDANCE	0.518054		76.02
76.03	03952 WOUND CARE	0.000000		76.03
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
91.00	09100 EMERGENCY	0.077658		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.219863		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

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

Provider CCN: 14-0084

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

Worksheet C
Part II
Date/Time Prepared:
4/30/2018 2:15 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		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,386,522	1,072,850	9,313,672	0	0	50.00
51.00	05100	RECOVERY ROOM	2,909,380	154,659	2,754,721	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,900,759	357,083	3,543,676	0	0	52.00
53.00	05300	ANESTHESIOLOGY	483,454	40,340	443,114	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,951,590	1,012,903	11,938,687	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	10,338,189	483,817	9,854,372	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,025,844	144,704	1,881,140	0	0	65.00
66.00	06600	PHYSICAL THERAPY	4,975,291	397,729	4,577,562	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,148,384	243,713	3,904,671	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,460,298	120,241	4,340,057	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,159,507	194,743	6,964,764	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,456,194	216,428	9,239,766	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,164,928	10,815	1,154,113	0	0	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.02	03951	GUIDANCE	233,118	2,827	230,291	0	0	76.02
76.03	03952	WOUND CARE	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	11,494,312	908,010	10,586,302	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,223,758	250,513	1,973,245	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	283,234	4,442	278,792	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	88,594,762	5,615,817	82,978,945	0	0	200.00
201.00		Less Observation Beds	2,223,758	250,513	1,973,245	0	0	201.00
202.00		Total (line 200 minus line 201)	86,371,004	5,365,304	81,005,700	0	0	202.00

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

Provider CCN: 14-0084

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

Worksheet C
Part II
Date/Time Prepared:
4/30/2018 2:15 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)	Title XIX	
					Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,386,522	235,036,117	0.044191	50.00
51.00	05100	RECOVERY ROOM	2,909,380	22,804,665	0.127578	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,900,759	10,761,648	0.362469	52.00
53.00	05300	ANESTHESIOLOGY	483,454	6,946,415	0.069598	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,951,590	237,195,031	0.054603	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0.000000	58.00
60.00	06000	LABORATORY	10,338,189	119,680,610	0.086381	60.00
65.00	06500	RESPIRATORY THERAPY	2,025,844	24,296,774	0.083379	65.00
66.00	06600	PHYSICAL THERAPY	4,975,291	25,197,567	0.197451	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	4,148,384	69,356,745	0.059812	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,460,298	11,024,329	0.404587	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,159,507	36,964,010	0.193689	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,456,194	140,744,984	0.067187	73.00
74.00	07400	RENAL DIALYSIS	1,164,928	6,118,080	0.190407	74.00
76.00	03020	CARDIAC REHAB	0	0	0.000000	76.00
76.02	03951	GUIDANCE	233,118	449,988	0.518054	76.02
76.03	03952	WOUND CARE	0	0	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	88.00
91.00	09100	EMERGENCY	11,494,312	148,011,866	0.077658	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,223,758	10,114,268	0.219863	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	283,234	0	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000	101.00
SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0.000000	116.00
200.00		Subtotal (sum of lines 50 thru 199)	88,594,762	1,104,703,097		200.00
201.00		Less Observation Beds	2,223,758	0		201.00
202.00		Total (line 200 minus line 201)	86,371,004	1,104,703,097		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet D Part I Date/Time Prepared: 4/30/2018 2:15 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,352,699	0	3,352,699	40,672	82.43	30.00
31.00	INTENSIVE CARE UNIT	505,736		505,736	4,908	103.04	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
43.00	NURSERY	112,123		112,123	3,554	31.55	43.00
200.00	Total (lines 30 through 199)	3,970,558		3,970,558	49,134		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	15,243	1,256,480				
31.00	INTENSIVE CARE UNIT	2,050	211,232				
40.00	SUBPROVIDER - IPF	0	0				
41.00	SUBPROVIDER - IRF	0	0				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	17,293	1,467,712				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet D Part II Date/Time Prepared: 4/30/2018 2:15 pm
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Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,072,850	235,036,117	0.004565	46,780,546	213,553	50.00
51.00	05100	RECOVERY ROOM	154,659	22,804,665	0.006782	2,410,868	16,351	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	357,083	10,761,648	0.033181	143,584	4,764	52.00
53.00	05300	ANESTHESIOLOGY	40,340	6,946,415	0.005807	1,035,105	6,011	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,012,903	237,195,031	0.004270	29,657,747	126,639	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	483,817	119,680,610	0.004043	27,090,889	109,528	60.00
65.00	06500	RESPIRATORY THERAPY	144,704	24,296,774	0.005956	10,461,418	62,308	65.00
66.00	06600	PHYSICAL THERAPY	397,729	25,197,567	0.015784	5,545,392	87,528	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	243,713	69,356,745	0.003514	18,334,642	64,428	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	120,241	11,024,329	0.010907	2,152,353	23,476	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	194,743	36,964,010	0.005268	10,964,293	57,760	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	216,428	140,744,984	0.001538	41,638,264	64,040	73.00
74.00	07400	RENAL DIALYSIS	10,815	6,118,080	0.001768	3,177,210	5,617	74.00
76.00	03020	CARDIAC REHAB	0	0	0.000000	0	0	76.00
76.02	03951	GUIDANCE	2,827	449,988	0.006282	9,610	60	76.02
76.03	03952	WOUND CARE	0	0	0.000000	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
91.00	09100	EMERGENCY	908,010	148,011,866	0.006135	16,439,971	100,859	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	250,513	10,114,268	0.024768	1,403,474	34,761	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	5,611,375	1,104,703,097		217,245,366	977,683	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet D Part III Date/Time Prepared: 4/30/2018 2:15 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	PPS	
			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	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
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 col. 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	40,672	0.00	15,243	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	4,908	0.00	2,050	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00	
43.00	04300	NURSERY	0	0	3,554	0.00	0	43.00	
200.00		Total (lines 30 through 199)	0	0	49,134	0.00	17,293	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
40.00	04000	SUBPROVIDER - IPF	0						40.00
41.00	04100	SUBPROVIDER - IRF	0						41.00
43.00	04300	NURSERY	0						43.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet D Part IV Date/Time Prepared: 4/30/2018 2:15 pm
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Cost Center Description	Title XVIII				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		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
54.01 05401 ULTRASOUND	0	0	0	0	0	0	54.01
56.00 05600 RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	0	57.00
58.00 05800 MRI	0	0	0	0	0	0	58.00
60.00 06000 LABORATORY	0	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	0	74.00
76.00 03020 CARDIAC REHAB	0	0	0	0	0	0	76.00
76.02 03951 GUIDANCE	0	0	0	0	0	0	76.02
76.03 03952 WOUND CARE	0	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
91.00 09100 EMERGENCY	0	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00 09500 AMBULANCE SERVICES	0	0	0	0	0	0	95.00
200.00 Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet D Part IV Date/Time Prepared: 4/30/2018 2:15 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		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	235,036,117	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	22,804,665	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	10,761,648	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	6,946,415	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	237,195,031	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	119,680,610	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	24,296,774	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	25,197,567	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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69,356,745	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	11,024,329	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	36,964,010	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	140,744,984	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	6,118,080	0.000000	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0.000000	76.00
76.02	03951	GUIDANCE	0	0	0	449,988	0.000000	76.02
76.03	03952	WOUND CARE	0	0	0	0	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	148,011,866	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	10,114,268	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	1,104,703,097		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet D Part IV Date/Time Prepared: 4/30/2018 2:15 pm
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Cost Center Description		Title XVIII				Hospital	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PPS
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	46,780,546	0	28,109,239	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	2,410,868	0	2,983,148	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	143,584	0	110,256	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	1,035,105	0	577,722	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	29,657,747	0	39,153,128	0	54.00
54.01	05401 ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MRI	0.000000	0	0	0	0	58.00
60.00	06000 LABORATORY	0.000000	27,090,889	0	5,754,270	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	10,461,418	0	644,860	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	5,545,392	0	66,680	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	18,334,642	0	8,060,363	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	2,152,353	0	771,436	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	10,964,293	0	4,468,422	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	41,638,264	0	11,747,118	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	3,177,210	0	68,568	0	74.00
76.00	03020 CARDIAC REHAB	0.000000	0	0	0	0	76.00
76.02	03951 GUIDANCE	0.000000	9,610	0	20,366	0	76.02
76.03	03952 WOUND CARE	0.000000	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100 EMERGENCY	0.000000	16,439,971	0	13,197,877	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,403,474	0	1,479,781	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		217,245,366	0	117,213,234	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet D Part V Date/Time Prepared: 4/30/2018 2:15 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			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.044191	28,109,239	0	0	1,242,175	50.00
51.00	05100	RECOVERY ROOM	0.127578	2,983,148	0	0	380,584	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.362469	110,256	0	0	39,964	52.00
53.00	05300	ANESTHESIOLOGY	0.069598	577,722	0	0	40,208	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.054603	39,153,128	0	0	2,137,878	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.086381	5,754,270	0	0	497,060	60.00
65.00	06500	RESPIRATORY THERAPY	0.083379	644,860	0	0	53,768	65.00
66.00	06600	PHYSICAL THERAPY	0.197451	66,680	0	0	13,166	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.059812	8,060,363	0	0	482,106	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.404587	771,436	0	0	312,113	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.193689	4,468,422	0	0	865,484	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.067187	11,747,118	109,112	0	789,254	73.00
74.00	07400	RENAL DIALYSIS	0.190407	68,568	0	0	13,056	74.00
76.00	03020	CARDIAC REHAB	0.000000	0	0	0	0	76.00
76.02	03951	GUIDANCE	0.518054	20,366	0	0	10,551	76.02
76.03	03952	WOUND CARE	0.000000	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.077658	13,197,877	0	0	1,024,921	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.219863	1,479,781	0	0	325,349	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		117,213,234	109,112	0	8,227,637	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		117,213,234	109,112	0	8,227,637	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet D Part V Date/Time Prepared: 4/30/2018 2:15 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.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 05401 ULTRASOUND	0	0		54.01
56.00 05600 RADIOISOTOPE	0	0		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MRI	0	0		58.00
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
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	7,331	0		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.00 03020 CARDIAC REHAB	0	0		76.00
76.02 03951 GUIDANCE	0	0		76.02
76.03 03952 WOUND CARE	0	0		76.03
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00 09500 AMBULANCE SERVICES	0	0		95.00
200.00 Subtotal (see instructions)	7,331	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0	0		201.00
202.00 Net Charges (line 200 - line 201)	7,331	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet D Part I Date/Time Prepared: 4/30/2018 2:15 pm
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Cost Center Description		Title XIX			Hospital	PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,352,699	0	3,352,699	40,672	82.43	30.00
31.00	INTENSIVE CARE UNIT	505,736		505,736	4,908	103.04	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
43.00	NURSERY	112,123		112,123	3,554	31.55	43.00
200.00	Total (lines 30 through 199)	3,970,558		3,970,558	49,134		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,365	112,517				
31.00	INTENSIVE CARE UNIT	125	12,880				
40.00	SUBPROVIDER - IPF	0	0				
41.00	SUBPROVIDER - IRF	0	0				
43.00	NURSERY	3,219	101,559				
200.00	Total (lines 30 through 199)	4,709	226,956				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet D Part II Date/Time Prepared: 4/30/2018 2:15 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
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1,072,850	235,036,117	0.004565	0	0 50.00
51.00	05100 RECOVERY ROOM	154,659	22,804,665	0.006782	0	0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	357,083	10,761,648	0.033181	0	0 52.00
53.00	05300 ANESTHESIOLOGY	40,340	6,946,415	0.005807	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,012,903	237,195,031	0.004270	0	0 54.00
54.01	05401 ULTRASOUND	0	0	0.000000	0	0 54.01
56.00	05600 RADIOISOTOPE	0	0	0.000000	0	0 56.00
57.00	05700 CT SCAN	0	0	0.000000	0	0 57.00
58.00	05800 MRI	0	0	0.000000	0	0 58.00
60.00	06000 LABORATORY	483,817	119,680,610	0.004043	0	0 60.00
65.00	06500 RESPIRATORY THERAPY	144,704	24,296,774	0.005956	0	0 65.00
66.00	06600 PHYSICAL THERAPY	397,729	25,197,567	0.015784	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	243,713	69,356,745	0.003514	0	0 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	120,241	11,024,329	0.010907	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	194,743	36,964,010	0.005268	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	216,428	140,744,984	0.001538	0	0 73.00
74.00	07400 RENAL DIALYSIS	10,815	6,118,080	0.001768	0	0 74.00
76.00	03020 CARDIAC REHAB	0	0	0.000000	0	0 76.00
76.02	03951 GUIDANCE	2,827	449,988	0.006282	0	0 76.02
76.03	03952 WOUND CARE	0	0	0.000000	0	0 76.03
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0 88.00
91.00	09100 EMERGENCY	908,010	148,011,866	0.006135	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	250,513	10,114,268	0.024768	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					95.00
200.00	Total (lines 50 through 199)	5,611,375	1,104,703,097		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet D Part III Date/Time Prepared: 4/30/2018 2:15 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	PPS	
			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	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
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 col. 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	40,672	0.00	1,365	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	4,908	0.00	125	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00	
43.00	04300	NURSERY	0	0	3,554	0.00	3,219	43.00	
200.00		Total (lines 30 through 199)	0	0	49,134	0.00	4,709	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
40.00	04000	SUBPROVIDER - IPF	0						40.00
41.00	04100	SUBPROVIDER - IRF	0						41.00
43.00	04300	NURSERY	0						43.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet D Part IV Date/Time Prepared: 4/30/2018 2:15 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		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	76.00
76.02	03951	GUI DANCE	0	0	0	0	76.02
76.03	03952	WOUND CARE	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
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: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet D Part IV Date/Time Prepared: 4/30/2018 2:15 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			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	235,036,117	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	22,804,665	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	10,761,648	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	6,946,415	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	237,195,031	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	119,680,610	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	24,296,774	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	25,197,567	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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69,356,745	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	11,024,329	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	36,964,010	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	140,744,984	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	6,118,080	0.000000	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0.000000	76.00
76.02	03951	GUIDANCE	0	0	0	449,988	0.000000	76.02
76.03	03952	WOUND CARE	0	0	0	0	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	148,011,866	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	10,114,268	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	1,104,703,097		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet D Part IV Date/Time Prepared: 4/30/2018 2:15 pm
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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	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
54.01 05401 ULTRASOUND	0.000000	0	0	0	0	54.01
56.00 05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00 05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00 05800 MRI	0.000000	0	0	0	0	58.00
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
69.00 06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00 03020 CARDIAC REHAB	0.000000	0	0	0	0	76.00
76.02 03951 GUIDANCE	0.000000	0	0	0	0	76.02
76.03 03952 WOUND CARE	0.000000	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00 09100 EMERGENCY	0.000000	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet D-1 Date/Time Prepared: 4/30/2018 2:15 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		40,672	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		40,672	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.		4,678	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		32,955	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		15,243	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		29,761,372	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)		29,761,372	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		110,468,070	28.00
29.00	Private room charges (excluding swing-bed charges)		13,346,206	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		97,121,864	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.269412	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		2,852.97	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		2,947.11	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)		29,761,372	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		731.74	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		11,153,913	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)		11,153,913	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet D-1 Date/Time Prepared: 4/30/2018 2:15 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)	
42.00	NURSERY (title V & XIX only)	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	8,011,599	4,908	1,632.36	2,050	3,346,338
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)				17,509,552	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				32,009,803	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				1,467,712	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				977,683	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				2,445,395	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				29,564,408	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)				3,039	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				731.74	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				2,223,758	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0084		Period: From 12/01/2016 To 11/30/2017		Worksheet D-1 Date/Time Prepared: 4/30/2018 2:15 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	3,352,699	29,761,372	0.112653	2,223,758	250,513	90.00
91.00	Nursing School cost	0	29,761,372	0.000000	2,223,758	0	91.00
92.00	Allied health cost	0	29,761,372	0.000000	2,223,758	0	92.00
93.00	All other Medical Education	0	29,761,372	0.000000	2,223,758	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet D-1 Date/Time Prepared: 4/30/2018 2:15 pm
Cost Center Description		Title XIX	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		40,672	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		40,672	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.		4,678	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		32,955	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)		1,365	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)		3,554	15.00
16.00	Nursery days (title V or XIX only)		3,219	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		29,761,372	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)		29,761,372	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		110,468,070	28.00
29.00	Private room charges (excluding swing-bed charges)		13,346,206	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		97,121,864	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.269412	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		2,852.97	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		2,947.11	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)		29,761,372	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		731.74	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		998,825	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)		998,825	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet D-1 Date/Time Prepared: 4/30/2018 2:15 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)		
42.00	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	2,155,227	3,554	606.42	3,219	1,952,066	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	8,011,599	4,908	1,632.36	125	204,045	43.00	
44.00						44.00	
45.00						45.00	
46.00						46.00	
47.00						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)					3,154,936	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)					226,956	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)					226,956	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,927,980	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)					3,039	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					731.74	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,223,758	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0084		Period: From 12/01/2016 To 11/30/2017		Worksheet D-1 Date/Time Prepared: 4/30/2018 2:15 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	3,352,699	29,761,372	0.112653	2,223,758	250,513	90.00
91.00	Nursing School cost	0	29,761,372	0.000000	2,223,758	0	91.00
92.00	Allied health cost	0	29,761,372	0.000000	2,223,758	0	92.00
93.00	All other Medical Education	0	29,761,372	0.000000	2,223,758	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet D-3 Date/Time Prepared: 4/30/2018 2:15 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		46,898,969	30.00
31.00	03100	INTENSIVE CARE UNIT		10,459,081	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.044191	46,780,546	2,067,279 50.00
51.00	05100	RECOVERY ROOM	0.127578	2,410,868	307,574 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.362469	143,584	52,045 52.00
53.00	05300	ANESTHESIOLOGY	0.069598	1,035,105	72,041 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.054603	29,657,747	1,619,402 54.00
54.01	05401	ULTRASOUND	0.000000	0	0 54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0 56.00
57.00	05700	CT SCAN	0.000000	0	0 57.00
58.00	05800	MRI	0.000000	0	0 58.00
60.00	06000	LABORATORY	0.086381	27,090,889	2,340,138 60.00
65.00	06500	RESPIRATORY THERAPY	0.083379	10,461,418	872,263 65.00
66.00	06600	PHYSICAL THERAPY	0.197451	5,545,392	1,094,943 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.059812	18,334,642	1,096,632 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.404587	2,152,353	870,814 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.193689	10,964,293	2,123,663 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.067187	41,638,264	2,797,550 73.00
74.00	07400	RENAL DIALYSIS	0.190407	3,177,210	604,963 74.00
76.00	03020	CARDIAC REHAB	0.000000	0	0 76.00
76.02	03951	GUI DANCE	0.518054	9,610	4,978 76.02
76.03	03952	WOUND CARE	0.000000	0	0 76.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0 88.00
91.00	09100	EMERGENCY	0.077658	16,439,971	1,276,695 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.219863	1,403,474	308,572 92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			
200.00		Total (sum of lines 50 through 94 and 96 through 98)		217,245,366	17,509,552 200.00
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)		217,245,366	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet E Part A Date/Time Prepared: 4/30/2018 2:15 pm
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		24,354,473	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		4,684,206	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)		285,900	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)		181.67	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		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
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		6.63	30.00
31.00	Percentage of Medicaid patient days (see instructions)		31.36	31.00
32.00	Sum of lines 30 and 31		37.99	32.00
33.00	Allowable disproportionate share percentage (see instructions)		20.56	33.00
34.00	Disproportionate share adjustment (see instructions)		1,492,588	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet E Part A Date/Time Prepared: 4/30/2018 2:15 pm	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)		0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		2,175,413	1,973,963	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		1,811,851	329,895	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		2,141,746		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
			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)		32,958,913		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)			32,958,913	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			2,567,602	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)			35,526,515	59.00
60.00	Primary payer payments			23,142	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			35,503,373	61.00
62.00	Deductibles billed to program beneficiaries			3,097,500	62.00
63.00	Coinurance billed to program beneficiaries			108,689	63.00
64.00	Allowable bad debts (see instructions)			1,128,862	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			733,760	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			941,989	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			33,030,944	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)			-123,835	70.93
70.94	HRR adjustment amount (see instructions)			-127,956	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet E Part A Date/Time Prepared: 4/30/2018 2:15 pm	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
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	1.00	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)			32,779,153	71.00
71.01	Sequestration adjustment (see instructions)			655,583	71.01
71.02	Demonstration payment adjustment amount after sequestration			0	71.02
72.00	Interim payments			31,710,511	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)			413,059	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			1,684,793	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	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)			0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)			0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			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: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet E Part B Date/Time Prepared: 4/30/2018 2:15 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		7,331	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		8,227,637	2.00
3.00	OPPS payments		9,631,149	3.00
4.00	Outlier payment (see instructions)		12,350	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)		7,331	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		109,112	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)		109,112	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a 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)		109,112	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		101,781	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)		7,331	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)		9,643,499	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		38,058	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,833,679	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		7,779,093	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		7,779,093	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		7,779,093	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		665,460	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		432,549	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		552,757	36.00
37.00	Subtotal (see instructions)		8,211,642	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)		8,211,642	40.00
40.01	Sequestration adjustment (see instructions)		164,233	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		8,019,108	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		28,301	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 14-0084		Period: From 12/01/2016 To 11/30/2017		Worksheet E-1 Part I Date/Time Prepared: 4/30/2018 2:15 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		31,065,111		7,623,838		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		645,400		395,270		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)		31,710,511		8,019,108		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		413,059		28,301		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		32,123,570		8,047,409		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: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet E-1 Part II Date/Time Prepared: 4/30/2018 2:15 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

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

Provider CCN: 14-0084

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

Worksheet G

Date/Time Prepared:
4/30/2018 2:15 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	-532,587	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	47,712,545	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-16,011,107	0	0	0	6.00
7.00	Inventory	3,809,228	0	0	0	7.00
8.00	Prepaid expenses	1,006,016	0	0	0	8.00
9.00	Other current assets	667,293	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)	36,651,388	0	0	0	11.00
FIXED ASSETS						
12.00	Land	11,309,704	0	0	0	12.00
13.00	Land improvements	2,581,275	0	0	0	13.00
14.00	Accumulated depreciation	-1,455,269	0	0	0	14.00
15.00	Buildings	54,523,784	0	0	0	15.00
16.00	Accumulated depreciation	-14,951,613	0	0	0	16.00
17.00	Leasehold improvements	23,340,298	0	0	0	17.00
18.00	Accumulated depreciation	-9,399,085	0	0	0	18.00
19.00	Fixed equipment	5,419,266	0	0	0	19.00
20.00	Accumulated depreciation	-3,273,019	0	0	0	20.00
21.00	Automobiles and trucks	135,178	0	0	0	21.00
22.00	Accumulated depreciation	-115,476	0	0	0	22.00
23.00	Major movable equipment	26,204,287	0	0	0	23.00
24.00	Accumulated depreciation	-23,640,803	0	0	0	24.00
25.00	Minor equipment depreciable	16,853,280	0	0	0	25.00
26.00	Accumulated depreciation	-15,279,166	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)	72,252,641	0	0	0	30.00
OTHER ASSETS						
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	2,842,342	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,842,342	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	111,746,371	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	25,240,027	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,754,053	0	0	0	38.00
39.00	Payroll taxes payable	671,681	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	-11,546,108	0	0	0	43.00
44.00	Other current liabilities	3,101,627	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	23,221,280	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	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)	23,221,280	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	88,525,091				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)	88,525,091	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	111,746,371	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0084

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

Worksheet G-1

Date/Time Prepared:
4/30/2018 2:15 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		91,922,048		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-3,396,961			2.00
3.00	Total (sum of line 1 and line 2)		88,525,087		0	3.00
4.00	ROUNDING	4		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)		4		0	10.00
11.00	Subtotal (line 3 plus line 10)		88,525,091		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)		88,525,091		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	ROUNDING		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: 14-0084

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
4/30/2018 2:15 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	117,302,463		117,302,463	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	0		0	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)	117,302,463		117,302,463	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	25,070,412		25,070,412	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)	25,070,412		25,070,412	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	142,372,875		142,372,875	17.00
18.00	Ancillary services	552,373,555	437,428,647	989,802,202	18.00
19.00	Outpatient services	0	114,900,895	114,900,895	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	694,746,430	552,329,542	1,247,075,972	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		153,206,673		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)		153,206,673		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0084

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

Worksheet G-3

Date/Time Prepared:
4/30/2018 2:15 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,247,075,972	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,097,841,536	2.00
3.00	Net patient revenues (line 1 minus line 2)	149,234,436	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	153,206,673	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,972,237	5.00
OTHER INCOME			
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	575,276	24.00
25.00	Total other income (sum of lines 6-24)	575,276	25.00
26.00	Total (line 5 plus line 25)	-3,396,961	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)	-3,396,961	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0084	Period: From 12/01/2016 To 11/30/2017	Worksheet L Parts I-III Date/Time Prepared: 4/30/2018 2:15 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		2,352,745	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		26,873	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)		118.05	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		6.63	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		31.36	8.00
9.00	Sum of lines 7 and 8		37.99	9.00
10.00	Allowable disproportionate share percentage (see instructions)		7.99	10.00
11.00	Disproportionate share adjustment (see instructions)		187,984	11.00
12.00	Total prospective capital payments (see instructions)		2,567,602	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00