

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0033	Period: From 12/01/2017 To 02/28/2018	Worksheet S Parts I-III Date/Time Prepared: 8/28/2018 3:15 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 8/28/2018	Time: 3:15 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by VISTA MEDICAL CENTER WEST (14-0033) for the cost reporting period beginning 12/01/2017 and ending 02/28/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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	0	28,879	0	0	1.00
2.00 Subprovider - IPF	0	65,506	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0	0	0		0	6.00
200.00 Total	0	65,506	28,879	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0033		Period: From 12/01/2017 To 02/28/2018		Worksheet S-2 Part I Date/Time Prepared: 8/27/2018 7:12 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:		Zip Code: 60085-		County: LAKE					
2.00 City: WAUKEGAN		State: IL									
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
				1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00
								V	XVIII	XIX	
Hospital and Hospital-Based Component Identification:											
3.00 Hospital		VI STA MEDICAL CENTER WEST		140033	29404	1	07/01/1966	N	P	P	3.00
4.00 Subprovider - IPF		VI STA MEDICAL CENTER MENTAL HEALTH		14S033	29404	4	01/01/1990	N	P	N	4.00
5.00 Subprovider - IRF		VI STA MEDICAL CENTER REHAB		14T033	29404	5	09/01/1989	N	P	N	5.00
6.00 Subprovider - (Other)											6.00
7.00 Swing Beds - SNF											7.00
8.00 Swing Beds - NF											8.00
9.00 Hospital-Based SNF											9.00
10.00 Hospital-Based NF											10.00
11.00 Hospital-Based OLTC											11.00
12.00 Hospital-Based HHA											12.00
13.00 Separately Certified ASC											13.00
14.00 Hospital-Based Hospice											14.00
15.00 Hospital-Based Health Clinic - RHC											15.00
16.00 Hospital-Based Health Clinic - FQHC											16.00
17.00 Hospital-Based (CMHC) I											17.00
18.00 Renal Dialysis											18.00
19.00 Other											19.00
							From:	To:			
							1.00	2.00			
20.00 Cost Reporting Period (mm/dd/yyyy)							12/01/2017	02/28/2018		20.00	
21.00 Type of Control (see instructions)							4			21.00	
Inpatient PPS Information											
22.00 Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (PickLe amendment hospital?) In column 2, enter "Y" for yes or "N" for no.							N	N		22.00	
22.01 Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)							N	N		22.01	
22.02 Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.							N	N		22.02	
22.03 Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.							N	N		22.03	
23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.								3	N		23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
				1.00	2.00	3.00	4.00	5.00	6.00		
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.				0	0	0	0	0	0	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.				0	0	0	0	0	0	0	25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0033	Period: From 12/01/2017 To 02/28/2018	Worksheet S-2 Part I Date/Time Prepared: 8/27/2018 7:12 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	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.		N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.		N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.		N	N	N		48.00
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	61.00
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	
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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) Teaching Hospitals that Claim Residents in Nonprovider Settings						62.01	0.00
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
	Program Name		Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
	1.00		2.00	3.00	4.00	5.00		
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

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
					1.00	2.00	3.00
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			Y			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N		0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			Y			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N		0	76.00

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						1.00			
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		N		90.00		
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N		N		91.00		
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N		92.00		
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N		N		93.00		
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N		N		94.00		
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00			0.00		95.00		
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N		N		96.00		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00			0.00		97.00		
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y		Y		98.00		
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y		Y		98.01		
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y		Y		98.02		
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N		N		98.03		
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N		N		98.04		
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y		Y		98.05		
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y		Y		98.06		
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: 14-0033	Period: From 12/01/2017 To 02/28/2018	Worksheet S-2 Part I Date/Time Prepared: 8/27/2018 7:12 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			
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:	0	0			118.01
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N				121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00
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: 14-0033	Period: From 12/01/2017 To 02/28/2018	Worksheet S-2 Part I Date/Time Prepared: 8/27/2018 7:12 pm		
1.00		2.00		3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.						
141.00	Name: QUORUM HEALTH CORPORATION	Contractor's Name: WPS		Contractor's Number: 10101		
142.00	Street: 1573 MALLORY LANE	PO Box:				
143.00	City: BRENTWOOD	State: TN		Zip Code: 37027		
				1.00		
144.00	Are provider based physicians' costs included in Worksheet A?				Y	144.00
				1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N	146.00
				1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N	149.00
		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)						
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
				1.00		
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: 14-0033		Period: From 12/01/2017 To 02/28/2018		Worksheet S-2 Part II Date/Time Prepared: 8/27/2018 7:12 pm	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
					Y/N		
					1.00		
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			Y	06/18/2018	Y	06/18/2018
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0033	Period: From 12/01/2017 To 02/28/2018	Worksheet S-2 Part II Date/Time Prepared: 8/27/2018 7:12 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		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.			N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		Y	12/31/2017	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00		2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	COURTNEY		DALTON	41.00
42.00	Enter the employer/company name of the cost report preparer.	QUORUM HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-221-3886		COURTNEY_DALTON@QUORUMHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0033	Period: From 12/01/2017 To 02/28/2018	Worksheet S-2 Part II Date/Time Prepared: 8/27/2018 7:12 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 MANAGEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0033

Period:
From 12/01/2017
To 02/28/2018

Worksheet S-3
Part I
Date/Time Prepared:
8/27/2018 7:12 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	30	2,700	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		30	2,700	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		30	2,700	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	40	3,600		0	16.00
17.00 SUBPROVIDER - IRF	41.00	41	3,690		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		111				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0033

Period:
From 12/01/2017
To 02/28/2018

Worksheet S-3
Part I
Date/Time Prepared:
8/27/2018 7:12 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents			
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll		
	6.00	7.00	8.00	9.00	10.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	0	0	0			1.00
2.00	HMO and other (see instructions)	0	0				2.00
3.00	HMO IPF Subprovider	74	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	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	0	0			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0	0	0	0.00	7.83	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	303	430	1,148	0.00	6.86	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						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	14.69	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0033

Period:
From 12/01/2017
To 02/28/2018

Worksheet S-3
Part I
Date/Time Prepared:
8/27/2018 7:12 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Title V	Title XVIII	Title XIX			
		11.00	12.00	13.00			14.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	0	0	0	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	0	0	0	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	34	86	184	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						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0033

Period:
From 12/01/2017
To 02/28/2018

Worksheet S-3
Part II
Date/Time Prepared:
8/27/2018 7:12 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	909,165	0	909,165	30,559.00	29.75
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		432,581	0	432,581	14,266.00	30.32
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		0	0	0	0.00	0.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		37,210	0	37,210	580.00	64.16
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		119,275	0	119,275		
18.00	Wage-related costs (other) (see instructions)		204	0	204		
19.00	Excluded areas		106,914	0	106,914		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	0	0	0	0.00	0.00
27.00	Administrative & General	5.00	26,274	0	26,274	1,365.00	19.25

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0033

Period:
From 12/01/2017
To 02/28/2018

Worksheet S-3
Part II
Date/Time Prepared:
8/27/2018 7:12 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.)	0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	50,354	0	50,354	1,808.00	27.85
31.00	Laundry & Linen Service	8.00	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	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	10.00	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	11.00	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	34,913	0	34,913	969.00	36.03
39.00	Central Services and Supply	14.00	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	12,947	0	12,947	229.00	56.54
41.00	Medical Records & Medical Records Library	16.00	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0033

Period:
From 12/01/2017
To 02/28/2018

Worksheet S-3
Part III
Date/Time Prepared:
8/27/2018 7:12 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)	909,165	0	909,165	30,559.00	29.75	1.00
2.00	Excluded area salaries (see instructions)	432,581	0	432,581	14,266.00	30.32	2.00
3.00	Subtotal salaries (line 1 minus line 2)	476,584	0	476,584	16,293.00	29.25	3.00
4.00	Subtotal other wages & related costs (see inst.)	37,210	0	37,210	580.00	64.16	4.00
5.00	Subtotal wage-related costs (see inst.)	119,479	0	119,479	0.00	25.07	5.00
6.00	Total (sum of lines 3 thru 5)	633,273	0	633,273	16,873.00	37.53	6.00
7.00	Total overhead cost (see instructions)	124,488	0	124,488	4,371.00	28.48	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0033	Period: From 12/01/2017 To 02/28/2018	Worksheet S-3 Part IV Date/Time Prepared: 8/27/2018 7:12 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		17,073	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)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		115,022	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		1,361	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		1,265	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		96	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		4,499	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		7,383	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		55,426	17.00
18.00	Medicare Taxes - Employers Portion Only		12,963	18.00
19.00	Unemployment Insurance		0	19.00
20.00	State or Federal Unemployment Taxes		10,898	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)		225,986	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS		204	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0033

Period:
From 12/01/2017
To 02/28/2018

Worksheet S-3
Part V
Date/Time Prepared:
8/27/2018 7:12 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	0	225,986	1.00
2.00	Hospital	0	225,986	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0033	Period: From 12/01/2017 To 02/28/2018	Worksheet S-10 Date/Time Prepared: 8/27/2018 7:12 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)			0.171481	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			474,365	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			554,827	5.00	
6.00	Medicaid charges			9,399,220	6.00	
7.00	Medicaid cost (line 1 times line 6)			1,611,788	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)			582,596	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)						
9.00	Net revenue from stand-alone CHIP			0	9.00	
10.00	Stand-alone CHIP charges			0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00	
Other state or local government indigent care program (see instructions for each line)						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)						
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			582,596	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)	1,696,891	7,469	1,704,360	20.00	
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	290,985	7,469	298,454	21.00	
22.00	Payments received from patients for amounts previously written off as charity care	350	0	350	22.00	
23.00	Cost of charity care (line 21 minus line 22)	290,635	7,469	298,104	23.00	
				1.00		
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00	
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)			761,928	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			110,690	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			170,292	27.01	
28.00	Non-Medicare bad debt expense (see instructions)			591,636	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			161,056	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			459,160	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			1,041,756	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0033

Period:
From 12/01/2017
To 02/28/2018

Worksheet A

Date/Time Prepared:
8/27/2018 7:12 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS								
1.00	00100		166,420	166,420	227,333	393,753	1.00	
2.00	00200		31,945	31,945	20,197	52,142	2.00	
4.00	00400		0	0	146,902	146,902	4.00	
5.00	00500	26,274	1,714,150	1,740,424	-372,969	1,367,455	5.00	
7.00	00700	50,354	386,779	437,133	780	437,913	7.00	
8.00	00800	0	8,935	8,935	0	8,935	8.00	
9.00	00900	0	71,995	71,995	0	71,995	9.00	
10.00	01000	0	178,337	178,337	0	178,337	10.00	
13.00	01300	34,913	2,818	37,731	0	37,731	13.00	
15.00	01500	12,947	37,064	50,011	-66,207	-16,196	15.00	
16.00	01600	0	19,719	19,719	28	19,747	16.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	0	0	0	0	0	30.00	
40.00	04000	432,581	44,453	477,034	-325	476,709	40.00	
41.00	04100	0	0	0	0	0	41.00	
ANCILLARY SERVICE COST CENTERS								
54.00	05400	3,518	15,460	18,978	79,056	98,034	54.00	
54.01	05401	8,055	10,043	18,098	-18,098	0	54.01	
57.00	05700	34,519	26,218	60,737	-60,737	0	57.00	
58.00	05800	239	23	262	-262	0	58.00	
60.00	06000	62,174	78,816	140,990	-4,523	136,467	60.00	
65.00	06500	0	8,645	8,645	-7,235	1,410	65.00	
66.00	06600	0	0	0	0	0	66.00	
67.00	06700	0	-32	-32	32	0	67.00	
68.00	06800	0	0	0	0	0	68.00	
71.00	07100	0	0	0	0	0	71.00	
73.00	07300	0	0	0	62,884	62,884	73.00	
76.00	03020	114,156	10,544	124,700	10	124,710	76.00	
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	129,435	198,218	327,653	-5,069	322,584	91.00	
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		909,165	3,010,550	3,919,715	1,797	3,921,512	118.00
NONREIMBURSABLE COST CENTERS								
190.02	19001	0	0	0	0	0	190.02	
192.00	19200	0	4,637	4,637	-4,468	169	192.00	
192.01	19201	0	0	0	2,671	2,671	192.01	
194.00	07950	0	0	0	0	0	194.00	
200.00	TOTAL (SUM OF LINES 118 through 199)		909,165	3,015,187	3,924,352	0	3,924,352	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0033

Period:
From 12/01/2017
To 02/28/2018

Worksheet A
Date/Time Prepared:
8/27/2018 7:12 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	-95,754	297,999	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	9,919	62,061	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	146,902	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-800,684	566,771	5.00
7.00	00700	OPERATION OF PLANT	56,422	494,335	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	8,935	8.00
9.00	00900	HOUSEKEEPING	188,260	260,255	9.00
10.00	01000	DIETARY	0	178,337	10.00
13.00	01300	NURSING ADMINISTRATION	0	37,731	13.00
15.00	01500	PHARMACY	0	-16,196	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	19,747	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00
40.00	04000	SUBPROVIDER - I PF	0	476,709	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	41.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	98,034	54.00
54.01	05401	ULTRA SOUND	0	0	54.01
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	0	136,467	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,410	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	62,884	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0	124,710	76.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-146,619	175,965	91.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-788,456	3,133,056	118.00
NONREIMBURSABLE COST CENTERS					
190.02	19001	WORKPOWER/CORP HEALTH	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	169	192.00
192.01	19201	VI STA MEDICAL CENTER EAST	0	2,671	192.01
194.00	07950	MARKETING	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-788,456	3,135,896	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	146,902	1.00
	O		0	146,902	
B - OXYGEN COST					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,205	1.00
2.00	OPERATION OF PLANT	7.00	0	796	2.00
	O		0	5,001	
C - RENT AND LEASE EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	20,197	1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	28	2.00
3.00	OCCUPATIONAL THERAPY	67.00	0	32	3.00
4.00	MENTAL HEALTH ANCILLARY	76.00	0	10	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
	O		0	20,267	
D - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	227,333	1.00
	O		0	227,333	
E - DRUGS AND IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	58,679	1.00
	O		0	58,679	
G - OTHER RADIOLOGY COSTS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	42,813	36,284	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	O		42,813	36,284	
H - MOB COSTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,797	1.00
2.00	VI STA MEDICAL CENTER EAST	192.01	0	2,671	2.00
	O		0	4,468	
500.00	Grand Total: Increases		42,813	498,934	500.00

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - EMPLOYEE BENEFITS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	146,902	0		1.00
	O		0	146,902			
B - OXYGEN COST							
1.00	RESPIRATORY THERAPY	65.00	0	5,001	0		1.00
2.00	O	0.00	0	0	0		2.00
			0	5,001			
C - RENT AND LEASE EXPENSE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	531	10		1.00
2.00	OPERATION OF PLANT	7.00	0	16	0		2.00
3.00	PHARMACY	15.00	0	7,528	0		3.00
4.00	SUBPROVIDER - IPF	40.00	0	325	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	41	0		5.00
6.00	LABORATORY	60.00	0	4,523	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	2,234	0		7.00
8.00	EMERGENCY	91.00	0	5,069	0		8.00
	O		0	20,267			
D - OTHER CAPITAL COSTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	227,333	13		1.00
	O		0	227,333			
E - DRUGS AND IV SOLUTIONS							
1.00	PHARMACY	15.00	0	58,679	0		1.00
	O		0	58,679			
G - OTHER RADIOLOGY COSTS							
1.00	ULTRA SOUND	54.01	8,055	10,043	0		1.00
2.00	CT SCAN	57.00	34,519	26,218	0		2.00
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	239	23	0		3.00
	O		42,813	36,284			
H - MOB COSTS							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	4,468	0		1.00
2.00	O	0.00	0	0	0		2.00
			0	4,468			
500.00	Grand Total: Decreases		42,813	498,934			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0033

Period:
From 12/01/2017
To 02/28/2018

Worksheet A-7
Part I
Date/Time Prepared:
8/27/2018 7:12 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	1,970,715	0	0	0	0	1.00
2.00	Land Improvements	534,566	0	0	0	0	2.00
3.00	Buildings and Fixtures	30,169,370	294,330	0	294,330	0	3.00
4.00	Building Improvements	2,970,310	0	0	0	0	4.00
5.00	Fixed Equipment	4,464,039	0	0	0	0	5.00
6.00	Movable Equipment	22,548,589	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	62,657,589	294,330	0	294,330	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	62,657,589	294,330	0	294,330	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,970,715	0				1.00
2.00	Land Improvements	534,566	0				2.00
3.00	Buildings and Fixtures	30,463,700	0				3.00
4.00	Building Improvements	2,970,310	0				4.00
5.00	Fixed Equipment	4,464,039	0				5.00
6.00	Movable Equipment	22,548,589	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	62,951,919	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	62,951,919	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0033

Period:
From 12/01/2017
To 02/28/2018

Worksheet A-7
Part II
Date/Time Prepared:
8/27/2018 7:12 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	166,420	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	31,945	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	198,365	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	166,420				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	31,945				2.00
3.00	Total (sum of lines 1-2)	0	198,365				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0033

Period:
From 12/01/2017
To 02/28/2018

Worksheet A-7
Part III
Date/Time Prepared:
8/27/2018 7:12 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	35,939,290	0	35,939,290	0.570901	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	27,012,629	0	27,012,629	0.429099	0	2.00
3.00	Total (sum of lines 1-2)	62,951,919	0	62,951,919	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	70,666	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	41,864	20,197	2.00
3.00	Total (sum of lines 1-2)	0	0	0	112,530	20,197	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	227,333	0	297,999	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	62,061	2.00
3.00	Total (sum of lines 1-2)	0	0	227,333	0	360,060	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0033

Period:
From 12/01/2017
To 02/28/2018

Worksheet A-8

Date/Time Prepared:
8/27/2018 7:12 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	-13		ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)	A	0		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	-284,720				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	60,305				0	12.00
13.00 Laundry and linen service		0			0.00	0	13.00
14.00 Cafeteria-employees and guests		0			0.00	0	14.00
15.00 Rental of quarters to employee and others		0			0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00	0	16.00
17.00 Sale of drugs to other than patients	B	0		DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00 Sale of medical records and abstracts	B	0		MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)	B	0		ADMINISTRATIVE & GENERAL	5.00	0	19.00
20.00 Vending machines		0			0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0		RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0		PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0		*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	A	-118,259		CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	A	6,854		CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00 Non-physician Anesthetist		0		*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant		0			0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0		OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)		0		ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0		SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0	32.00
33.00 RENTAL INCOME	B	-2,368		CAP REL COSTS-BLDG & FIXT	1.00	9	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0033

Period:
From 12/01/2017
To 02/28/2018

Worksheet A-8

Date/Time Prepared:
8/27/2018 7:12 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
33.01 LOBBYING EXPENSE	A	-238	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02 FITNESS REVENUE	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03 MSHIPS/PROF DUES/SUB	A	-13,311	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04 LEGAL FEES	A	-1,336	ADMINISTRATIVE & GENERAL	5.00	0	33.04
35.00 TRAINING REVENUE	B	0	NURSING ADMINISTRATION	13.00	0	35.00
36.00 PHONE & TV DEPRECIATION	A	-559	CAP REL COSTS-MVBLE EQUIP	2.00	9	36.00
36.01 TV CABLE EXPENSE	A	-40	ADMINISTRATIVE & GENERAL	5.00	0	36.01
37.00 STATE OPERATING TAX	A	-685,384	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00 MISC REVENUE	B	0	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00 ALLOCATED SECURITY / PLANT OPS	A	56,422	OPERATION OF PLANT	7.00	0	39.00
40.00 ALLOCATED HOUSEKEEPING	A	188,260	HOUSEKEEPING	9.00	0	40.00
44.00 ALLOCATED EKG	A	5,931	EMERGENCY	91.00	0	44.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-788,456				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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

Provider CCN: 14-0033

Period:
From 12/01/2017
To 02/28/2018

Worksheet A-8-1

Date/Time Prepared:
8/27/2018 7:12 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	5.00	ADMINISTRATIVE & GENERAL	ALLOCATION FROM VISTA EAST	26,479	0
2.00	5.00	ADMINISTRATIVE & GENERAL	OHC SPECIFIC COSTS	49,860	0
3.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - BLDG &	24,873	0
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS - MOVEABL	3,624	0
4.01	5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL HOME OFFICE COST	35,928	0
4.02	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	80,459
4.03	0.00			0	0
4.04	0.00			0	0
4.05	0.00			0	0
4.06	0.00			0	0
4.07	0.00			0	0
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			140,764	80,459

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

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

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

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

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

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

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

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

Provider CCN: 14-0033

Period:
From 12/01/2017
To 02/28/2018

Worksheet A-8-1

Date/Time Prepared:
8/27/2018 7:12 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	26,479	0		1.00
2.00	49,860	0		2.00
3.00	24,873	9		3.00
4.00	3,624	9		4.00
4.01	35,928	0		4.01
4.02	-80,459	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
5.00	60,305			5.00

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

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0033

Period:
From 12/01/2017
To 02/28/2018

Worksheet A-8-2

Date/Time Prepared:
8/27/2018 7:12 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	132,170	132,170	0	0	0	1.00
2.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	152,550	152,550	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			284,720	284,720	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	132,170	1.00
2.00	40.00	SUBPROVIDER - IPF	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	152,550	3.00
4.00	0.00		0	0	0	0	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	284,720	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0033

Period:
From 12/01/2017
To 02/28/2018

Worksheet B
Part I
Date/Time Prepared:
8/27/2018 7:12 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	297,999	297,999			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	62,061		62,061		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	146,902	0	0	146,902	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	566,771	11,992	2,497	4,245	5.00
7.00 00700	OPERATION OF PLANT	494,335	191,522	39,887	8,136	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	8,935	4,163	867	0	8.00
9.00 00900	HOUSEKEEPING	260,255	9,372	1,952	0	9.00
10.00 01000	DIETARY	178,337	2,493	519	0	10.00
13.00 01300	NURSING ADMINISTRATION	37,731	0	0	5,641	13.00
15.00 01500	PHARMACY	-16,196	5,135	1,069	2,092	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	19,747	2,193	457	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
40.00 04000	SUBPROVIDER - IPF	476,709	28,985	6,036	69,897	40.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	41.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	98,034	0	0	7,486	54.00
54.01 05401	ULTRA SOUND	0	0	0	0	54.01
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00 06000	LABORATORY	136,467	83	17	10,046	60.00
65.00 06500	RESPIRATORY THERAPY	1,410	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
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	62,884	0	0	0	73.00
76.00 03020	MENTAL HEALTH ANCILLARY	124,710	7,009	1,460	18,445	76.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	175,965	21,661	4,511	20,914	91.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	3,133,056	284,608	59,272	146,902	118.00
NONREIMBURSABLE COST CENTERS						
190.02 19001	WORKPOWER/CORP HEALTH	0	13,391	2,789	0	190.02
192.00 19200	PHYSICIANS' PRIVATE OFFICES	169	0	0	0	192.00
192.01 19201	VISTA MEDICAL CENTER EAST	2,671	0	0	0	192.01
194.00 07950	MARKETING	0	0	0	0	194.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	3,135,896	297,999	62,061	146,902	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
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	585,505				5.00
7.00	00700	OPERATION OF PLANT	167,958	901,838			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,196	39,732	56,893		8.00
9.00	00900	HOUSEKEEPING	62,155	89,456	0	423,190	9.00
10.00	01000	DIETARY	41,505	23,793	0	13,032	259,679
13.00	01300	NURSING ADMINISTRATION	9,926	0	0	0	0
15.00	01500	PHARMACY	0	49,015	0	26,846	0
16.00	01600	MEDICAL RECORDS & LIBRARY	5,126	20,935	0	11,466	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0
40.00	04000	SUBPROVIDER - I/PF	133,115	276,657	32,561	151,528	259,679
41.00	04100	SUBPROVIDER - I/RF	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,150	0	0	0	0
54.01	05401	ULTRA SOUND	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
60.00	06000	LABORATORY	33,555	789	0	432	0
65.00	06500	RESPIRATORY THERAPY	323	0	0	0	0
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	14,392	0	0	0	0
76.00	03020	MENTAL HEALTH ANCILLARY	34,702	66,901	0	36,643	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	51,049	206,747	24,332	113,238	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	581,152	774,025	56,893	353,185	259,679
NONREIMBURSABLE COST CENTERS							
190.02	19001	WORKPOWER/CORP HEALTH	3,703	127,813	0	70,005	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	39	0	0	0	0
192.01	19201	VISTA MEDICAL CENTER EAST	611	0	0	0	0
194.00	07950	MARKETING	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	585,505	901,838	56,893	423,190	259,679

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	15.00	16.00	24.00	25.00	
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	53,298					13.00
15.00	01500	0	67,961				15.00
16.00	01600	0	0	59,924			16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	0	0	0	0	30.00
40.00	04000	53,298	0	12,327	1,500,792	0	40.00
41.00	04100	0	0	0	0	0	41.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	0	10,325	139,995	0	54.00
54.01	05401	0	0	0	0	0	54.01
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	0	0	7,923	189,312	0	60.00
65.00	06500	0	0	146	1,879	0	65.00
66.00	06600	0	0	0	0	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	67,961	3,791	149,028	0	73.00
76.00	03020	0	0	2,232	292,102	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	0	0	23,180	641,597	0	91.00
SPECIAL PURPOSE COST CENTERS							
118.00		53,298	67,961	59,924	2,914,705	0	118.00
NONREIMBURSABLE COST CENTERS							
190.02	19001	0	0	0	217,701	0	190.02
192.00	19200	0	0	0	208	0	192.00
192.01	19201	0	0	0	3,282	0	192.01
194.00	07950	0	0	0	0	0	194.00
200.00					0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		53,298	67,961	59,924	3,135,896	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		Total	
		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
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
40.00	04000	SUBPROVIDER - IPF	40.00
41.00	04100	SUBPROVIDER - IRF	41.00
ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	ULTRA SOUND	54.01
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	76.00
OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	91.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		118.00
NONREIMBURSABLE COST CENTERS			
190.02	19001	WORKPOWER/CORP HEALTH	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	VISTA MEDICAL CENTER EAST	192.01
194.00	07950	MARKETING	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0033

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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	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	11,992	2,497	14,489	5.00
7.00 00700	OPERATION OF PLANT	0	191,522	39,887	231,409	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	4,163	867	5,030	8.00
9.00 00900	HOUSEKEEPING	0	9,372	1,952	11,324	9.00
10.00 01000	DIETARY	0	2,493	519	3,012	10.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	13.00
15.00 01500	PHARMACY	0	5,135	1,069	6,204	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	2,193	457	2,650	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
40.00 04000	SUBPROVIDER - IPF	0	28,985	6,036	35,021	40.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	41.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01 05401	ULTRA SOUND	0	0	0	0	54.01
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00 06000	LABORATORY	0	83	17	100	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
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03020	MENTAL HEALTH ANCILLARY	0	7,009	1,460	8,469	76.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0	21,661	4,511	26,172	91.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	284,608	59,272	343,880	118.00
NONREIMBURSABLE COST CENTERS						
190.02 19001	WORKPOWER/CORP HEALTH	0	13,391	2,789	16,180	190.02
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01 19201	VISTA MEDICAL CENTER EAST	0	0	0	0	192.01
194.00 07950	MARKETING	0	0	0	0	194.00
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	297,999	62,061	360,060	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
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	14,489				5.00
7.00	00700	OPERATION OF PLANT	4,156	235,565			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	79	10,378	15,487		8.00
9.00	00900	HOUSEKEEPING	1,538	23,366	0	36,228	9.00
10.00	01000	DIETARY	1,027	6,215	0	1,116	11,370
13.00	01300	NURSING ADMINISTRATION	246	0	0	0	13.00
15.00	01500	PHARMACY	0	12,803	0	2,298	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	127	5,468	0	982	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
40.00	04000	SUBPROVIDER - I PF	3,294	72,266	8,863	12,971	11,370
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	41.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	598	0	0	0	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	830	206	0	37	60.00
65.00	06500	RESPIRATORY THERAPY	8	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	356	0	0	0	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	859	17,475	0	3,137	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	1,263	54,003	6,624	9,694	91.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,381	202,180	15,487	30,235	11,370
NONREIMBURSABLE COST CENTERS							
190.02	19001	WORKPOWER/CORP HEALTH	92	33,385	0	5,993	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1	0	0	0	192.00
192.01	19201	VI STA MEDICAL CENTER EAST	15	0	0	0	192.01
194.00	07950	MARKETING	0	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	14,489	235,565	15,487	36,228	11,370

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0033	Period: From 12/01/2017 To 02/28/2018	Worksheet B Part II Date/Time Prepared: 8/27/2018 7:12 pm	
Cost Center Description	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments
	13.00	15.00	16.00	24.00	25.00
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	246			13.00
15.00 01500	PHARMACY	0	17,205		15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	9,227	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	0	0	0	0 30.00
40.00 04000	SUBPROVIDER - I PF	246	0	1,898	145,929 0 40.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0 41.00
ANCILLARY SERVICE COST CENTERS					
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	1,590	2,188 0 54.00
54.01 05401	ULTRA SOUND	0	0	0	0 54.01
57.00 05700	CT SCAN	0	0	0	0 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0 58.00
60.00 06000	LABORATORY	0	0	1,220	2,393 0 60.00
65.00 06500	RESPIRATORY THERAPY	0	0	22	30 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
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0 71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	17,205	584	18,145 0 73.00
76.00 03020	MENTAL HEALTH ANCILLARY	0	0	344	30,284 0 76.00
OUTPATIENT SERVICE COST CENTERS					
91.00 09100	EMERGENCY	0	0	3,569	101,325 0 91.00
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	246	17,205	9,227	300,294 0 118.00
NONREIMBURSABLE COST CENTERS					
190.02 19001	WORKPOWER/CORP HEALTH	0	0	0	55,650 0 190.02
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1 0 192.00
192.01 19201	VI STA MEDICAL CENTER EAST	0	0	0	15 0 192.01
194.00 07950	MARKETING	0	0	0	0 194.00
200.00	Cross Foot Adjustments				0 200.00
201.00	Negative Cost Centers	0	4,100	0	4,100 0 201.00
202.00	TOTAL (sum lines 118 through 201)	246	21,305	9,227	360,060 0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description		Total	
		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
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
40.00	04000	SUBPROVIDER - IPF	40.00
41.00	04100	SUBPROVIDER - IRF	41.00
ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	ULTRA SOUND	54.01
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	76.00
OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	91.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		118.00
NONREIMBURSABLE COST CENTERS			
190.02	19001	WORKPOWER/CORP HEALTH	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	VISTA MEDICAL CENTER EAST	192.01
194.00	07950	MARKETING	194.00
200.00	Cross Foot Adjustments		200.00
201.00	Negative Cost Centers		201.00
202.00	TOTAL (sum lines 118 through 201)		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0033

Period:
From 12/01/2017
To 02/28/2018

Worksheet B-1
Date/Time Prepared:
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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				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	208,961				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		208,961			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	909,165		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	8,409	8,409	26,274	-585,505	2,558,291
7.00 00700	OPERATION OF PLANT	134,297	134,297	50,354	0	733,880
8.00 00800	LAUNDRY & LINEN SERVICE	2,919	2,919	0	0	13,965
9.00 00900	HOUSEKEEPING	6,572	6,572	0	0	271,579
10.00 01000	DIETARY	1,748	1,748	0	0	181,349
13.00 01300	NURSING ADMINISTRATION	0	0	34,913	0	43,372
15.00 01500	PHARMACY	3,601	3,601	12,947	7,900	0
16.00 01600	MEDICAL RECORDS & LIBRARY	1,538	1,538	0	0	22,397
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	0	0	0	0
40.00 04000	SUBPROVIDER - I/PF	20,325	20,325	432,581	0	581,627
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	46,331	0	105,520
54.01 05401	ULTRA SOUND	0	0	0	0	0
57.00 05700	CT SCAN	0	0	0	0	0
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
60.00 06000	LABORATORY	58	58	62,174	0	146,613
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	1,410
66.00 06600	PHYSICAL THERAPY	0	0	0	0	0
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	62,884
76.00 03020	MENTAL HEALTH ANCILLARY	4,915	4,915	114,156	0	151,624
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	15,189	15,189	129,435	0	223,051
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	199,571	199,571	909,165	-577,605	2,539,271
NONREIMBURSABLE COST CENTERS						
190.02 19001	WORKPOWER/CORP HEALTH	9,390	9,390	0	0	16,180
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	169
192.01 19201	VISTA MEDICAL CENTER EAST	0	0	0	0	2,671
194.00 07950	MARKETING	0	0	0	0	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	297,999	62,061	146,902		585,505
203.00	Unit cost multiplier (Wkst. B, Part I)	1.426099	0.296998	0.161579		0.228866
204.00	Cost to be allocated (per Wkst. B, Part II)			0		14,489
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.005664
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0033

Period:
From 12/01/2017
To 02/28/2018

Worksheet B-1

Date/Time Prepared:
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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	66,255				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	2,919	110,326			8.00	
9.00	00900	HOUSEKEEPING	6,572	0	56,764		9.00	
10.00	01000	DIETARY	1,748	0	1,748	26,831	10.00	
13.00	01300	NURSING ADMINISTRATION	0	0	0	432,581	13.00	
15.00	01500	PHARMACY	3,601	0	3,601	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	1,538	0	1,538	0	16.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00	
40.00	04000	SUBPROVIDER - I PF	20,325	63,141	20,325	26,831	432,581	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	58	0	58	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	4,915	0	4,915	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	15,189	47,185	15,189	0	0	91.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	56,865	110,326	47,374	26,831	432,581	118.00
NONREIMBURSABLE COST CENTERS								
190.02	19001	WORKPOWER/CORP HEALTH	9,390	0	9,390	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	VI STA MEDICAL CENTER EAST	0	0	0	0	0	192.01
194.00	07950	MARKETING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	901,838	56,893	423,190	259,679	53,298	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.611622	0.515681	7.455253	9.678320	0.123209	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	235,565	15,487	36,228	11,370	246	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.555430	0.140375	0.638221	0.423764	0.000569	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0033

Period:
From 12/01/2017
To 02/28/2018

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		15.00	16.00	
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			13.00
15.00	01500	58,679		15.00
16.00	01600	0	16,997,215	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	0	0	30.00
40.00	04000	0	3,496,045	40.00
41.00	04100	0	0	41.00
ANCILLARY SERVICE COST CENTERS				
54.00	05400	0	2,928,170	54.00
54.01	05401	0	0	54.01
57.00	05700	0	0	57.00
58.00	05800	0	0	58.00
60.00	06000	0	2,246,937	60.00
65.00	06500	0	41,291	65.00
66.00	06600	0	0	66.00
67.00	06700	0	0	67.00
68.00	06800	0	0	68.00
71.00	07100	0	0	71.00
73.00	07300	58,679	1,075,127	73.00
76.00	03020	0	633,118	76.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100	0	6,576,527	91.00
SPECIAL PURPOSE COST CENTERS				
118.00		58,679	16,997,215	118.00
NONREIMBURSABLE COST CENTERS				
190.02	19001	0	0	190.02
192.00	19200	0	0	192.00
192.01	19201	0	0	192.01
194.00	07950	0	0	194.00
200.00				200.00
201.00				201.00
202.00		67,961	59,924	202.00
203.00		1.158183	0.003526	203.00
204.00		21,305	9,227	204.00
205.00		0.293205	0.000543	205.00
206.00				206.00
207.00				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0033

Period:
From 12/01/2017
To 02/28/2018

Worksheet C
Part I
Date/Time Prepared:
8/27/2018 7:12 pm

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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	0		0	0	0 30.00	
40.00	04000 SUBPROVIDER - IPF	1,500,792		1,500,792	0	1,500,792 40.00	
41.00	04100 SUBPROVIDER - IRF	0		0	0	0 41.00	
ANCILLARY SERVICE COST CENTERS							
54.00	05400 RADIOLOGY-DIAGNOSTIC	139,995		139,995	0	139,995 54.00	
54.01	05401 ULTRA SOUND	0		0	0	0 54.01	
57.00	05700 CT SCAN	0		0	0	0 57.00	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0 58.00	
60.00	06000 LABORATORY	189,312		189,312	0	189,312 60.00	
65.00	06500 RESPIRATORY THERAPY	1,879	0	1,879	0	1,879 65.00	
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0 66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0 67.00	
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0 68.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0 71.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	149,028		149,028	0	149,028 73.00	
76.00	03020 MENTAL HEALTH ANCILLARY	292,102		292,102	0	292,102 76.00	
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	641,597		641,597	0	641,597 91.00	
200.00	Subtotal (see instructions)	2,914,705	0	2,914,705	0	2,914,705 200.00	
201.00	Less Observation Beds	0		0	0	0 201.00	
202.00	Total (see instructions)	2,914,705	0	2,914,705	0	2,914,705 202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0033

Period:
From 12/01/2017
To 02/28/2018

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0		0		30.00
40.00	04000	SUBPROVIDER - I/PF	3,496,045		3,496,045		40.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	98,077	2,830,093	2,928,170	0.047810	54.00
54.01	05401	ULTRA SOUND	0	0	0	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	207,219	2,039,718	2,246,937	0.084253	60.00
65.00	06500	RESPIRATORY THERAPY	1,335	39,956	41,291	0.045506	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	582,772	492,355	1,075,127	0.138614	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	58,445	574,673	633,118	0.461371	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	472,015	6,104,512	6,576,527	0.097559	91.00
200.00		Subtotal (see instructions)	4,915,908	12,081,307	16,997,215		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	4,915,908	12,081,307	16,997,215		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0033	Period: From 12/01/2017 To 02/28/2018	Worksheet C Part I Date/Time Prepared: 8/27/2018 7:12 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
40.00	04000	SUBPROVIDER - I PF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
ANCI LLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DI AGNOSTIC	0.047810		54.00
54.01	05401	ULTRA SOUND	0.000000		54.01
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.084253		60.00
65.00	06500	RESPI RATORY THERAPY	0.045506		65.00
66.00	06600	PHYSI CAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.138614		73.00
76.00	03020	MENTAL HEALTH ANCI LLARY	0.461371		76.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.097559		91.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0033

Period:
From 12/01/2017
To 02/28/2018

Worksheet C
Part I
Date/Time Prepared:
8/27/2018 7:12 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX		Hospital		PPS
				Total Costs	RCE Disallowance	Total Costs		
								Costs
30.00	03000 ADULTS & PEDIATRICS	0		0	0	0	0	30.00
40.00	04000 SUBPROVIDER - IPF	1,500,792		1,500,792	0	1,500,792	0	40.00
41.00	04100 SUBPROVIDER - IRF	0		0	0	0	0	41.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400 RADIOLOGY-DIAGNOSTIC	139,995		139,995	0	139,995	0	54.00
54.01	05401 ULTRA SOUND	0		0	0	0	0	54.01
57.00	05700 CT SCAN	0		0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	0	58.00
60.00	06000 LABORATORY	189,312		189,312	0	189,312	0	60.00
65.00	06500 RESPIRATORY THERAPY	1,879	0	1,879	0	1,879	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
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	149,028		149,028	0	149,028	0	73.00
76.00	03020 MENTAL HEALTH ANCILLARY	292,102		292,102	0	292,102	0	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100 EMERGENCY	641,597		641,597	0	641,597	0	91.00
200.00	Subtotal (see instructions)	2,914,705	0	2,914,705	0	2,914,705	0	200.00
201.00	Less Observation Beds	0		0		0		201.00
202.00	Total (see instructions)	2,914,705	0	2,914,705	0	2,914,705	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0033	Period: From 12/01/2017 To 02/28/2018	Worksheet C Part I Date/Time Prepared: 8/27/2018 7:12 pm
		Title XIX	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0		0	30.00
40.00	04000	SUBPROVIDER - I/PF	3,496,045		3,496,045	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	41.00
ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	98,077	2,830,093	2,928,170	54.00
54.01	05401	ULTRA SOUND	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
60.00	06000	LABORATORY	207,219	2,039,718	2,246,937	60.00
65.00	06500	RESPIRATORY THERAPY	1,335	39,956	41,291	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	582,772	492,355	1,075,127	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	58,445	574,673	633,118	76.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	472,015	6,104,512	6,576,527	91.00
200.00		Subtotal (see instructions)	4,915,908	12,081,307	16,997,215	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	4,915,908	12,081,307	16,997,215	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0033	Period: From 12/01/2017 To 02/28/2018	Worksheet C Part I Date/Time Prepared: 8/27/2018 7:12 pm
Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital
			11.00		PPS
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
40.00	04000	SUBPROVIDER - I PF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.047810		54.00
54.01	05401	ULTRA SOUND	0.000000		54.01
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.084253		60.00
65.00	06500	RESPIRATORY THERAPY	0.045506		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.138614		73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0.461371		76.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.097559		91.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 14-0033

Period:
From 12/01/2017
To 02/28/2018

Worksheet C
Part II
Date/Time Prepared:
8/27/2018 7:12 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	
ANCI LLARY SERVI CE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	139,995	2,188	137,807	0	0	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	189,312	2,393	186,919	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,879	30	1,849	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	149,028	18,145	130,883	0	0	73.00
76.00	03020	MENTAL HEALTH ANCI LLARY	292,102	30,284	261,818	0	0	76.00
OUTPATIENT SERVI CE COST CENTERS								
91.00	09100	EMERGENCY	641,597	101,325	540,272	0	0	91.00
200.00		Subtotal (sum of lines 50 thru 199)	1,413,913	154,365	1,259,548	0	0	200.00
201.00		Less Observation Beds	0	0	0	0	0	201.00
202.00		Total (line 200 minus line 201)	1,413,913	154,365	1,259,548	0	0	202.00

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

Provider CCN: 14-0033

Period:
From 12/01/2017
To 02/28/2018

Worksheet C
Part II
Date/Time Prepared:
8/27/2018 7:12 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
		6.00	7.00	8.00		
Title XIX						
		Hospital		PPS		
ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	139,995	2,928,170	0.047810	54.00
54.01	05401	ULTRA SOUND	0	0	0.000000	54.01
57.00	05700	CT SCAN	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	58.00
60.00	06000	LABORATORY	189,312	2,246,937	0.084253	60.00
65.00	06500	RESPIRATORY THERAPY	1,879	41,291	0.045506	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	149,028	1,075,127	0.138614	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	292,102	633,118	0.461371	76.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	641,597	6,576,527	0.097559	91.00
200.00		Subtotal (sum of lines 50 thru 199)	1,413,913	13,501,170		200.00
201.00		Less Observation Beds	0	0		201.00
202.00		Total (line 200 minus line 201)	1,413,913	13,501,170		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-0033		Period: From 12/01/2017 To 02/28/2018		Worksheet D Part I Date/Time Prepared: 8/27/2018 7:12 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	0	0	0	0	0.00	
40.00	SUBPROVIDER - IPF	145,929	0	145,929	1,148	127.12	
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	
200.00	Total (Lines 30 through 199)	145,929		145,929	1,148	200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	0	0	30.00			
40.00	SUBPROVIDER - IPF	303	38,517	40.00			
41.00	SUBPROVIDER - IRF	0	0	41.00			
200.00	Total (Lines 30 through 199)	303	38,517	200.00			

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 14-0033	Period: From 12/01/2017 To 02/28/2018	Worksheet D Part II Date/Time Prepared: 8/27/2018 7:12 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital PPS							
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,188	2,928,170	0.000747	0	0 54.00
54.01	05401	ULTRA SOUND	0	0	0.000000	0	0 54.01
57.00	05700	CT SCAN	0	0	0.000000	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0 58.00
60.00	06000	LABORATORY	2,393	2,246,937	0.001065	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	30	41,291	0.000727	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0.000000	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,145	1,075,127	0.016877	0	0 73.00
76.00	03020	MENTAL HEALTH ANCILLARY	30,284	633,118	0.047833	0	0 76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	101,325	6,576,527	0.015407	0	0 91.00
200.00		Total (lines 50 through 199)	154,365	13,501,170		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0033		Period: From 12/01/2017 To 02/28/2018		Worksheet D Part III Date/Time Prepared: 8/27/2018 7:12 pm		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	41.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	200.00
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0.00	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	1,148	0.00	303	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	0	41.00
200.00		Total (lines 30 through 199)	0	0	1,148	0.00	303	0	200.00
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
40.00	04000	SUBPROVIDER - IPF	0						40.00
41.00	04100	SUBPROVIDER - IRF	0						41.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0033	Period: From 12/01/2017 To 02/28/2018	Worksheet D Part IV Date/Time Prepared: 8/27/2018 7:12 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							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	91.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0033	Period: From 12/01/2017 To 02/28/2018	Worksheet D Part IV Date/Time Prepared: 8/27/2018 7:12 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								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,928,170	0.000000	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	2,246,937	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	41,291	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,075,127	0.000000	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0	0	0	633,118	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	6,576,527	0.000000	91.00
200.00		Total (lines 50 through 199)	0	0	0	13,501,170		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0033

Period:
From 12/01/2017
To 02/28/2018

Worksheet D
Part IV
Date/Time Prepared:
8/27/2018 7:12 pm

Cost Center Description		Title XVIII			Hospital	PPS		
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	211,298	0	54.00
54.01	05401	ULTRA SOUND	0.000000	0	0	0	0	54.01
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	115,800	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	3,591	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	45,102	0	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0.000000	0	0	67,096	0	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.000000	0	0	444,945	0	91.00
200.00		Total (lines 50 through 199)		0	0	887,832	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0033	Period: From 12/01/2017 To 02/28/2018	Worksheet D Part V Date/Time Prepared: 8/27/2018 7:12 pm
Title XVIII		Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	PPS Services (see inst.)	
		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		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
54.00 05400	RADIOLOGY-DIAGNOSTIC	0.047810	211,298	0	0	10,102	54.00
54.01 05401	ULTRA SOUND	0.000000	0	0	0	0	54.01
57.00 05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00 06000	LABORATORY	0.084253	115,800	0	0	9,756	60.00
65.00 06500	RESPIRATORY THERAPY	0.045506	3,591	0	0	163	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
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0.138614	45,102	197	0	6,252	73.00
76.00 03020	MENTAL HEALTH ANCILLARY	0.461371	67,096	0	0	30,956	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00 09100	EMERGENCY	0.097559	444,945	0	0	43,408	91.00
200.00	Subtotal (see instructions)		887,832	197	0	100,637	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 - line 201)		887,832	197	0	100,637	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0033	Period: From 12/01/2017 To 02/28/2018	Worksheet D Part V Date/Time Prepared: 8/27/2018 7:12 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					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	ULTRA SOUND	0	0	54.01
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27	0	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	91.00
200.00		Subtotal (see instructions)	27	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	27	0	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0033 Component CCN: 14-S033		Period: From 12/01/2017 To 02/28/2018		Worksheet D Part II Date/Time Prepared: 8/27/2018 7:12 pm		
				Title XVIII		Subprovider - IPF	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,188	2,928,170	0.000747	11,080	8	54.00
54.01	05401	ULTRA SOUND	0	0	0.000000	0	0	54.01
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	2,393	2,246,937	0.001065	65,576	70	60.00
65.00	06500	RESPIRATORY THERAPY	30	41,291	0.000727	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0.000000	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,145	1,075,127	0.016877	194,093	3,276	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	30,284	633,118	0.047833	14,416	690	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	101,325	6,576,527	0.015407	87,086	1,342	91.00
200.00		Total (lines 50 through 199)	154,365	13,501,170		372,251	5,386	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0033 Component CCN: 14-S033	Period: From 12/01/2017 To 02/28/2018	Worksheet D Part IV Date/Time Prepared: 8/27/2018 7:12 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01 05401 ULTRA SOUND	0	0	0	0	0	54.01
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 03020 MENTAL HEALTH ANCILLARY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
200.00 Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 14-0033 Component CCN: 14-S033		Period: From 12/01/2017 To 02/28/2018		Worksheet D Part IV Date/Time Prepared: 8/27/2018 7:12 pm		
				Title XVIII		Subprovider - IPF	PPS	
Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,928,170	0.000000	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	2,246,937	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	41,291	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,075,127	0.000000	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0	0	0	633,118	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	6,576,527	0.000000	91.00
200.00		Total (lines 50 through 199)	0	0	0	13,501,170		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 14-0033 Component CCN: 14-S033		Period: From 12/01/2017 To 02/28/2018		Worksheet D Part IV Date/Time Prepared: 8/27/2018 7:12 pm	
				Title XVIII		Subprovider - IPF	
Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	11,080	0	0	54.00
54.01	05401	ULTRA SOUND	0.000000	0	0	0	54.01
57.00	05700	CT SCAN	0.000000	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	65,576	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	194,093	0	0	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0.000000	14,416	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.000000	87,086	0	0	91.00
200.00		Total (lines 50 through 199)		372,251	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0033 Component CCN: 14-T033		Period: From 12/01/2017 To 02/28/2018		Worksheet D Part II Date/Time Prepared: 8/27/2018 7:12 pm		
				Title XVIII		Subprovider - IRF	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,188	2,928,170	0.000747	0	0	54.00
54.01	05401	ULTRA SOUND	0	0	0.000000	0	0	54.01
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	2,393	2,246,937	0.001065	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	30	41,291	0.000727	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0.000000	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,145	1,075,127	0.016877	0	0	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	30,284	633,118	0.047833	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	101,325	6,576,527	0.015407	0	0	91.00
200.00		Total (lines 50 through 199)	154,365	13,501,170		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0033 Component CCN: 14-T033	Period: From 12/01/2017 To 02/28/2018	Worksheet D Part IV Date/Time Prepared: 8/27/2018 7:12 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01 05401 ULTRA SOUND	0	0	0	0	0	54.01
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 03020 MENTAL HEALTH ANCILLARY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
200.00 Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 14-0033 Component CCN: 14-T033		Period: From 12/01/2017 To 02/28/2018		Worksheet D Part IV Date/Time Prepared: 8/27/2018 7:12 pm		
				Title XVIII		Subprovider - IRF	PPS	
Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,928,170	0.000000	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	2,246,937	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	41,291	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,075,127	0.000000	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0	0	0	633,118	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	6,576,527	0.000000	91.00
200.00		Total (lines 50 through 199)	0	0	0	13,501,170		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 14-0033 Component CCN: 14-T033		Period: From 12/01/2017 To 02/28/2018		Worksheet D Part IV Date/Time Prepared: 8/27/2018 7:12 pm	
				Title XVIII		Subprovider - IRF	PPS
Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	54.00
54.01	05401	ULTRA SOUND	0.000000	0	0	0	54.01
57.00	05700	CT SCAN	0.000000	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0.000000	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.000000	0	0	0	91.00
200.00		Total (lines 50 through 199)		0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-0033		Period: From 12/01/2017 To 02/28/2018		Worksheet D Part I Date/Time Prepared: 8/27/2018 7:12 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	0	0	0	0	0.00	30.00
40.00	SUBPROVIDER - IPF	145,929	0	145,929	1,148	127.12	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
200.00	Total (Lines 30 through 199)	145,929		145,929	1,148		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	0	0				
40.00	SUBPROVIDER - IPF	430	54,662				
41.00	SUBPROVIDER - IRF	0	0				
200.00	Total (Lines 30 through 199)	430	54,662				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 14-0033	Period: From 12/01/2017 To 02/28/2018	Worksheet D Part II Date/Time Prepared: 8/27/2018 7:12 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,188	2,928,170	0.000747	0	0	54.00
54.01	05401 ULTRA SOUND	0	0	0.000000	0	0	54.01
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
60.00	06000 LABORATORY	2,393	2,246,937	0.001065	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	30	41,291	0.000727	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0.000000	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
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	18,145	1,075,127	0.016877	0	0	73.00
76.00	03020 MENTAL HEALTH ANCILLARY	30,284	633,118	0.047833	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	101,325	6,576,527	0.015407	0	0	91.00
200.00	Total (lines 50 through 199)	154,365	13,501,170		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0033	Period: From 12/01/2017 To 02/28/2018	Worksheet D Part III Date/Time Prepared: 8/27/2018 7:12 pm
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Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of 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	0	0.00	0	30.00	
40.00	04000	SUBPROVIDER - IPF	0	0	1,148	0.00	430	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00	
200.00		Total (lines 30 through 199)	0	0	1,148		430	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
40.00	04000	SUBPROVIDER - IPF	0						40.00
41.00	04100	SUBPROVIDER - IRF	0						41.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0033	Period: From 12/01/2017 To 02/28/2018	Worksheet D Part IV Date/Time Prepared: 8/27/2018 7:12 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							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	91.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0033	Period: From 12/01/2017 To 02/28/2018	Worksheet D Part IV Date/Time Prepared: 8/27/2018 7:12 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								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,928,170	0.000000	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	2,246,937	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	41,291	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,075,127	0.000000	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0	0	0	633,118	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	6,576,527	0.000000	91.00
200.00		Total (lines 50 through 199)	0	0	0	13,501,170		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0033

Period:
From 12/01/2017
To 02/28/2018

Worksheet D
Part IV
Date/Time Prepared:
8/27/2018 7:12 pm

Cost Center Description			Title XIX			Hospital	PPS	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
54.01	05401	ULTRA SOUND	0.000000	0	0	0	0	54.01
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0033	Period: From 12/01/2017 To 02/28/2018	Worksheet D-1 Date/Time Prepared: 8/27/2018 7:12 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)		0	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		0	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		0	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
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)		0	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		0	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		0	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)		0.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		0	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		0	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0033	Period: From 12/01/2017 To 02/28/2018	Worksheet D-1 Date/Time Prepared: 8/27/2018 7:12 pm
Title XVIII			Hospital		PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					0 49.00
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0 54.00
55.00 Target amount per discharge					0.00 55.00
56.00 Target amount (line 54 x line 55)					0 56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00 Bonus payment (see instructions)					0 58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00 Relief payment (see instructions)					0 62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					0 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0033		Period: From 12/01/2017 To 02/28/2018		Worksheet D-1 Date/Time Prepared: 8/27/2018 7:12 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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0033 Component CCN: 14-S033	Period: From 12/01/2017 To 02/28/2018	Worksheet D-1 Date/Time Prepared: 8/27/2018 7:12 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,148	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,148	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,148	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)		303	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)		1,500,792	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,500,792	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,500,792	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)		1,307.31	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		396,115	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)		396,115	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0033 Component CCN: 14-S033		Period: From 12/01/2017 To 02/28/2018		Worksheet D-1 Date/Time Prepared: 8/27/2018 7:12 pm		
		Title XVIII		Subprovider - IPF		PPS		
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)						42.00	
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT						43.00	
44.00	CORONARY CARE UNIT						44.00	
45.00	BURN INTENSIVE CARE UNIT						45.00	
46.00	SURGICAL INTENSIVE CARE UNIT						46.00	
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00	
Cost Center Description								
		1.00						
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48,106	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						444,221	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)						38,517	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						5,386	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						43,903	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						400,318	53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
56.00	Target amount (line 54 x line 55)						0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00	Bonus payment (see instructions)						0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00	Relief payment (see instructions)						0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)						0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0033 Component CCN: 14-S033		Period: From 12/01/2017 To 02/28/2018		Worksheet D-1 Date/Time Prepared: 8/27/2018 7:12 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	145,929	1,500,792	0.097235	0	0	90.00
91.00	Nursing School cost	0	1,500,792	0.000000	0	0	91.00
92.00	Allied health cost	0	1,500,792	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,500,792	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0033 Component CCN: 14-T033	Period: From 12/01/2017 To 02/28/2018	Worksheet D-1 Date/Time Prepared: 8/27/2018 7:12 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			0 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			0 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			0 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			0 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
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)			0 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			0 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			0 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)			0.00 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			0 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			0 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0033 Component CCN: 14-T033		Period: From 12/01/2017 To 02/28/2018		Worksheet D-1 Date/Time Prepared: 8/27/2018 7:12 pm		
		Title XVIII		Subprovider - IRF		PPS		
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)						42.00	
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT						43.00	
44.00	CORONARY CARE UNIT						44.00	
45.00	BURN INTENSIVE CARE UNIT						45.00	
46.00	SURGICAL INTENSIVE CARE UNIT						46.00	
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00	
Cost Center Description								
		1.00						
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)							0 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)							0 49.00
PASS THROUGH COST ADJUSTMENTS								
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)							0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)							0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)							0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)							0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges							0 54.00
55.00	Target amount per discharge							0.00 55.00
56.00	Target amount (line 54 x line 55)							0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							0 57.00
58.00	Bonus payment (see instructions)							0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket							0.00 59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket							0.00 60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							0 61.00
62.00	Relief payment (see instructions)							0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)							0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)							0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)							0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)							0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)							0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)							0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)							0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)							0.00 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)							0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0033 Component CCN: 14-T033		Period: From 12/01/2017 To 02/28/2018		Worksheet D-1 Date/Time Prepared: 8/27/2018 7:12 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0033	Period: From 12/01/2017 To 02/28/2018	Worksheet D-1 Date/Time Prepared: 8/27/2018 7:12 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)		0	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		0	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		0	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
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)		0	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		0	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		0	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)		0.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		0	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		0	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0033	Period: From 12/01/2017 To 02/28/2018	Worksheet D-1 Date/Time Prepared: 8/27/2018 7:12 pm
Title XIX			Hospital		PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				42.00
Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT				43.00
44.00	CORONARY CARE UNIT				44.00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00	SURGICAL INTENSIVE CARE UNIT				46.00
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00
Cost Center Description					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				0 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				0 49.00
PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges				0 54.00
55.00	Target amount per discharge				0.00 55.00
56.00	Target amount (line 54 x line 55)				0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0 57.00
58.00	Bonus payment (see instructions)				0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00 59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00 60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0 61.00
62.00	Relief payment (see instructions)				0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)				70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				71.00
72.00	Program routine service cost (line 9 x line 71)				72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)				73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)				74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)				76.00
77.00	Program capital-related costs (line 9 x line 76)				77.00
78.00	Inpatient routine service cost (line 74 minus line 77)				78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)				79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				80.00
81.00	Inpatient routine service cost per diem limitation				81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				82.00
83.00	Reasonable inpatient routine service costs (see instructions)				83.00
84.00	Program inpatient ancillary services (see instructions)				84.00
85.00	Utilization review - physician compensation (see instructions)				85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)				86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)				0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0033		Period: From 12/01/2017 To 02/28/2018		Worksheet D-1 Date/Time Prepared: 8/27/2018 7:12 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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0033 Component CCN: 14-S033	Period: From 12/01/2017 To 02/28/2018	Worksheet D-3 Date/Time Prepared: 8/27/2018 7:12 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
40.00	04000	SUBPROVIDER - IPF		1,136,765	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.047810	11,080	530
54.01	05401	ULTRA SOUND	0.000000	0	0
57.00	05700	CT SCAN	0.000000	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0
60.00	06000	LABORATORY	0.084253	65,576	5,525
65.00	06500	RESPIRATORY THERAPY	0.045506	0	0
66.00	06600	PHYSICAL THERAPY	0.000000	0	0
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.138614	194,093	26,904
76.00	03020	MENTAL HEALTH ANCILLARY	0.461371	14,416	6,651
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.097559	87,086	8,496
200.00		Total (sum of lines 50 through 94 and 96 through 98)		372,251	48,106
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0
202.00		Net charges (line 200 minus line 201)		372,251	48,106

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0033	Period: From 12/01/2017 To 02/28/2018	Worksheet E Part A Date/Time Prepared: 8/27/2018 7:12 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)		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		0	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)		0	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		30.00	4.00
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)		0.00	30.00
31.00	Percentage of Medicaid patient days (see instructions)		0.00	31.00
32.00	Sum of lines 30 and 31		0.00	32.00
33.00	Allowable disproportionate share percentage (see instructions)		0.00	33.00
34.00	Disproportionate share adjustment (see instructions)		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0033	Period: From 12/01/2017 To 02/28/2018	Worksheet E Part A Date/Time Prepared: 8/27/2018 7:12 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)		0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		0	0	36.00
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)		0		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			0	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			0	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			0	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			0	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			0	61.00
62.00	Deductibles billed to program beneficiaries			0	62.00
63.00	Coinurance billed to program beneficiaries			0	63.00
64.00	Allowable bad debts (see instructions)			0	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			0	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			0	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)				70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			0	70.93
70.94	HRR adjustment amount (see instructions)			0	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0033	Period: From 12/01/2017 To 02/28/2018	Worksheet E Part A Date/Time Prepared: 8/27/2018 7:12 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		0	71.00
71.01	Sequestration adjustment (see instructions)		0	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		0	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		0	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
			Prior to 10/1	On/After 10/1
			1.00	2.00
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	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: 14-0033	Period: From 12/01/2017 To 02/28/2018	Worksheet E Part B Date/Time Prepared: 8/27/2018 7:12 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		27	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		100,637	2.00
3.00	OPPS payments		76,795	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		27	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		197	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)		197	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)		197	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		170	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)		27	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)		76,795	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		11	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		18,537	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)		58,274	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)		58,274	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		58,274	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)		45,355	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		29,481	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		36,293	36.00
37.00	Subtotal (see instructions)		87,755	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)		87,755	40.00
40.01	Sequestration adjustment (see instructions)		1,755	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		57,121	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		28,879	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: 14-0033		Period: From 12/01/2017 To 02/28/2018		Worksheet E-1 Part I Date/Time Prepared: 8/27/2018 7:12 pm	
		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		0		57,121	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		0		57,121	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		28,879	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		0		86,000	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0033
Component CCN: 14-S033

Period:
From 12/01/2017
To 02/28/2018

Worksheet E-1
Part I
Date/Time Prepared:
8/27/2018 7:12 pm

Title XVIII

Subprovider -
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		225,355		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		14,079		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		239,434		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		65,506		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		304,940		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0033	Period: From 12/01/2017 To 02/28/2018	Worksheet E-1 Part II Date/Time Prepared: 8/27/2018 7:12 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0033 Component CCN: 14-S033	Period: From 12/01/2017 To 02/28/2018	Worksheet E-3 Part II Date/Time Prepared: 8/27/2018 7:12 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		266,193	1.00
2.00	Net IPF PPS Outlier Payments		0	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		12.755556	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line } 8/\text{line } 9))) \text{ raised to the power of } .5150 - 1\}$.		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		266,193	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		266,193	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		266,193	18.00
19.00	Deductibles		30,580	19.00
20.00	Subtotal (line 18 minus line 19)		235,613	20.00
21.00	Coinsurance		5,659	21.00
22.00	Subtotal (line 20 minus line 21)		229,954	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		124,937	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		81,209	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		98,000	25.00
26.00	Subtotal (sum of lines 22 and 24)		311,163	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	27.00
28.00	Other pass through costs (see instructions)		0	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	30.50
30.99	Demonstration payment adjustment amount before sequestration		0	30.99
31.00	Total amount payable to the provider (see instructions)		311,163	31.00
31.01	Sequestration adjustment (see instructions)		6,223	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	31.02
32.00	Interim payments		239,434	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)		65,506	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		128,239	35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0033 Component CCN: 14-T033	Period: From 12/01/2017 To 02/28/2018	Worksheet E-3 Part III Date/Time Prepared: 8/27/2018 7:12 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)		0	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0.0000	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		0	3.00
4.00	Outlier Payments		0	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)		0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	5.01
6.00	New Teaching program adjustment. (see instructions)		0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)		0.00	9.00
10.00	Average Daily Census (see instructions)		0.000000	10.00
11.00	Teaching Adjustment Factor (see instructions)		0.000000	11.00
12.00	Teaching Adjustment (see instructions)		0	12.00
13.00	Total PPS Payment (see instructions)		0	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)		0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)		0	16.00
17.00	Subtotal (see instructions)		0	17.00
18.00	Primary payer payments		0	18.00
19.00	Subtotal (line 17 less line 18).		0	19.00
20.00	Deductibles		0	20.00
21.00	Subtotal (line 19 minus line 20)		0	21.00
22.00	Coinsurance		0	22.00
23.00	Subtotal (line 21 minus line 22)		0	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)		0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	26.00
27.00	Subtotal (sum of lines 23 and 25)		0	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	28.00
29.00	Other pass through costs (see instructions)		0	29.00
30.00	Outlier payments reconciliation		0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	31.50
31.99	Demonstration payment adjustment amount before sequestration		0	31.99
32.00	Total amount payable to the provider (see instructions)		0	32.00
32.01	Sequestration adjustment (see instructions)		0	32.01
32.02	Demonstration payment adjustment amount after sequestration		0	32.02
33.00	Interim payments		0	33.00
34.00	Tentative settlement (for contractor use only)		0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)		0	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4		0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

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

Provider CCN: 14-0033

Period:
From 12/01/2017
To 02/28/2018

Worksheet G

Date/Time Prepared:
8/27/2018 7:12 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	1,018	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,471,585	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,587,806	0	0	0	6.00
7.00	Inventory	23,922	0	0	0	7.00
8.00	Prepaid expenses	78,044	0	0	0	8.00
9.00	Other current assets	46,673	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)	3,033,436	0	0	0	11.00
FIXED ASSETS						
12.00	Land	4,217,077	0	0	0	12.00
13.00	Land improvements	4,304,292	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	10,455,946	0	0	0	15.00
16.00	Accumulated depreciation	-4,073,403	0	0	0	16.00
17.00	Leasehold improvements	1,660,155	0	0	0	17.00
18.00	Accumulated depreciation	-870,319	0	0	0	18.00
19.00	Fixed equipment	1,404,632	0	0	0	19.00
20.00	Accumulated depreciation	-680,042	0	0	0	20.00
21.00	Automobiles and trucks	17,338	0	0	0	21.00
22.00	Accumulated depreciation	-17,338	0	0	0	22.00
23.00	Major movable equipment	2,179,042	0	0	0	23.00
24.00	Accumulated depreciation	-2,119,335	0	0	0	24.00
25.00	Minor equipment depreciable	1,389,960	0	0	0	25.00
26.00	Accumulated depreciation	-1,372,565	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	16,495,440	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	-252,119	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	-252,119	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	19,276,757	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,192,826	0	0	0	37.00
38.00	Salaries, wages, and fees payable	415,810	0	0	0	38.00
39.00	Payroll taxes payable	0	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	-996,135	0	0	0	43.00
44.00	Other current liabilities	1,055,996	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,668,497	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)	1,668,497	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	17,608,260				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)	17,608,260	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	19,276,757	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0033

Period:
From 12/01/2017
To 02/28/2018

Worksheet G-1

Date/Time Prepared:
8/27/2018 7:12 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		19,151,081		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-1,542,820			2.00
3.00	Total (sum of line 1 and line 2)		17,608,261		0	3.00
4.00	ROUNDING	-1		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)		-1		0	10.00
11.00	Subtotal (line 3 plus line 10)		17,608,260		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)		17,608,260		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: 14-0033

Period:
From 12/01/2017
To 02/28/2018

Worksheet G-2
Parts I & II
Date/Time Prepared:
8/27/2018 7:12 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	0		0	1.00
2.00	SUBPROVIDER - IPF	3,496,045		3,496,045	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)	3,496,045		3,496,045	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,496,045		3,496,045	17.00
18.00	Ancillary services	1,419,863	492,355	1,912,218	18.00
19.00	Outpatient services	0	11,588,952	11,588,952	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	4,915,908	12,081,307	16,997,215	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		3,924,352		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)		3,924,352		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0033

Period:
From 12/01/2017
To 02/28/2018

Worksheet G-3

Date/Time Prepared:
8/27/2018 7:12 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	16,997,215	1.00
2.00	Less contractual allowances and discounts on patients' accounts	14,618,051	2.00
3.00	Net patient revenues (line 1 minus line 2)	2,379,164	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	3,924,352	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,545,188	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 (SPECIFY)	2,368	24.00
25.00	Total other income (sum of lines 6-24)	2,368	25.00
26.00	Total (line 5 plus line 25)	-1,542,820	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)	-1,542,820	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0033	Period: From 12/01/2017 To 02/28/2018	Worksheet L Parts I-III Date/Time Prepared: 8/27/2018 7:12 pm
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			0 1.00
1.01	Model 4 BPCI Capital DRG other than outlier			0 1.01
2.00	Capital DRG outlier payments			0 2.00
2.01	Model 4 BPCI Capital DRG outlier payments			0 2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		0.00	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)			0 6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)			0 11.00
12.00	Total prospective capital payments (see instructions)			0 12.00
				1.00
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