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 12/01/2015 To 11/30/2016	Worksheet S Parts I-III Date/Time Prepared: 4/28/2017 1:03 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 4/28/2017 Time: 1:03 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY 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 12/01/2015 and ending 11/30/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed)_____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-19,267	17,030	9,506	0	1.00
2.00	Subprovider - IPF	0	-33,701	-13		0	2.00
3.00	Subprovider - IRF	0	2,299	-12		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-50,669	17,005	9,506	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 12/01/2015 To 11/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 4/28/2017 12:59 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1324 NORTH SHERIDAN ROAD	PO Box:			1.00
2.00	City: WAUKEGAN	State: IL	Zip Code: 60085-	County: LAKE	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	VISTA MEDICAL CENTER WEST	140033	29404	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF	VISTA MEDICAL CENTER MENTAL HEALTH	14S033	29404	4	01/01/1990	N	P	N	4.00
5.00	Subprovider - IRF	VISTA 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: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	12/01/2015	11/30/2016	20.00
21.00	Type of Control (see instructions)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	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.	2,035	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.	332	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 4/28/2017 12:59 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)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	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 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
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 4/28/2017 12:59 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 4/28/2017 12:59 pm

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y			70.00
71.00	If line 70 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 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

		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 a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00

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		V	XIX	
		1.00	2.00	
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
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no.	N	110.00

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	92,995	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 state health or similar taxes? 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 4/28/2017 12:59 pm

		1.00	2.00	
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	449008	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: COMMUNITY HEALTH SYSTEMS	Contractor's Name: WPS	Contractor's Number: 10101	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.50	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0033	Period: From 12/01/2015 To 11/30/2016	Worksheet S-2 Part I Date/Time Prepared: 4/28/2017 12:59 pm

		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)	04/01/2016	06/29/2016	170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet S-2 Part II | Date/Time Prepared: 4/28/2017 12:59 pm

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

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	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	03/16/2017	Y	03/16/2017	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet S-2 Part II Date/Time Prepared: 4/28/2017 12:59 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					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	12/31/2015	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.	AMBER		WALKER		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.	615-221-3646		AMBER_WALKER@QUORUMHEALTH.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0033	Period: From 12/01/2015 To 11/30/2016	Worksheet S-2 Part II Date/Time Prepared: 4/28/2017 12:59 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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 12/01/2015 To 11/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 4/28/2017 12:59 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	16	5,856	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		16	5,856	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		16	5,856	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	26	9,516		0	16.00
17.00	SUBPROVIDER - IRF	41.00	25	9,150		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)		67				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 4/28/2017 12:59 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)	8	2,035	2,698			1.00
2.00	HMO and other (see instructions)	18	0				2.00
3.00	HMO IPF Subprovider	335	0				3.00
4.00	HMO IRF Subprovider	172	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	8	2,035	2,698			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)	8	2,035	2,698	0.00	74.21	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,065	3,110	5,760	0.00	21.37	16.00
17.00	SUBPROVIDER - IRF	2,118	332	3,345	0.00	16.04	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	111.62	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 4/28/2017 12:59 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1	332	443	1.00
2.00	HMO and other (see instructions)			2	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	1	332	443	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	143	539	961	16.00
17.00	SUBPROVIDER - IRF	0.00	0	148	27	232	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						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet S-3 Part II Date/Time Prepared: 4/28/2017 12:59 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	7,382,560	0	7,382,560	232,164.00	31.80	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		2,520,508	0	2,520,508	77,817.00	32.39	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		200	0	200	4.00	50.00	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		526,423	0	526,423	15,535.00	33.89	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		923,881	0	923,881			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		485,839	0	485,839			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related		0	0	0			25.50
25.51	Related orgainzation wage-related		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	181,658	0	181,658	10,409.00	17.45	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet S-3 Part II Date/Time Prepared: 4/28/2017 12:59 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		14,421	0	14,421	600.00	24.04	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	216,667	0	216,667	8,506.00	25.47	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	150,995	0	150,995	4,281.00	35.27	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet S-3 Part III Date/Time Prepared: 4/28/2017 12:59 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		7,396,981	0	7,396,981	232,764.00	31.78	1.00
2.00	Excluded area salaries (see instructions)		2,520,508	0	2,520,508	77,817.00	32.39	2.00
3.00	Subtotal salaries (line 1 minus line 2)		4,876,473	0	4,876,473	154,947.00	31.47	3.00
4.00	Subtotal other wages & related costs (see inst.)		526,623	0	526,623	15,539.00	33.89	4.00
5.00	Subtotal wage-related costs (see inst.)		923,881	0	923,881	0.00	18.95	5.00
6.00	Total (sum of lines 3 thru 5)		6,326,977	0	6,326,977	170,486.00	37.11	6.00
7.00	Total overhead cost (see instructions)		563,741	0	563,741	23,796.00	23.69	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet S-3 Part IV Date/Time Prepared: 4/28/2017 12:59 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	125,998	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)	554,436	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	5,481	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	5,654	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	390	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	23,435	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	113,961	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	435,920	17.00
18.00	Medicare Taxes - Employers Portion Only	101,949	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	41,356	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)	1,408,580	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER BENEFITS	1,139	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet S-3 Part V | Date/Time Prepared: 4/28/2017 12:59 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	200	1,408,580	1.00
2.00	Hospital	200	1,408,580	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 12/01/2015 To 11/30/2016 | Worksheet S-10 | Date/Time Prepared: 4/28/2017 12:59 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.128576	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,973,401	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	1,734,793	5.00
6.00	Medicaid charges	56,441,554	6.00
7.00	Medicaid cost (line 1 times line 6)	7,257,029	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	2,548,835	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
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,548,835	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	508,681	52,062	560,743	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	65,404	6,694	72,098	21.00
22.00	Partial payment by patients approved for charity care	613	253	866	22.00
23.00	Cost of charity care (line 21 minus line 22)	64,791	6,441	71,232	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,557,182	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	83,548	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	2,473,634	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	318,050	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	389,282	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,938,117	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet A | Date/Time Prepared: 4/28/2017 12:59 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		642,018	642,018	-75,088	566,930	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		131,401	131,401	46,563	177,964	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	830,494	830,494	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	181,658	4,739,913	4,921,571	-750,761	4,170,810	5.00
7.00	00700	OPERATION OF PLANT	216,667	1,264,768	1,481,435	1,979	1,483,414	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	154,360	154,360	0	154,360	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	0	9.00
10.00	01000	DIETARY	0	291,371	291,371	0	291,371	10.00
13.00	01300	NURSING ADMINISTRATION	150,995	12,008	163,003	0	163,003	13.00
15.00	01500	PHARMACY	0	226,666	226,666	-224,738	1,928	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	24,308	24,308	0	24,308	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	828,660	74,466	903,126	0	903,126	30.00
40.00	04000	SUBPROVIDER - IPF	1,377,444	150,705	1,528,149	0	1,528,149	40.00
41.00	04100	SUBPROVIDER - IRF	1,143,064	262,209	1,405,273	-1,951	1,403,322	41.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,245	24,463	35,708	286,848	322,556	54.00
54.01	05401	ULTRA SOUND	14,024	9,990	24,014	-24,014	0	54.01
57.00	05700	CT SCAN	182,840	79,994	262,834	-262,834	0	57.00
60.00	06000	LABORATORY	812,444	404,842	1,217,286	-14,115	1,203,171	60.00
65.00	06500	RESPIRATORY THERAPY	0	19,780	19,780	-5,243	14,537	65.00
66.00	06600	PHYSICAL THERAPY	456,903	57,379	514,282	296,071	810,353	66.00
67.00	06700	OCCUPATIONAL THERAPY	193,376	18,750	212,126	-212,126	0	67.00
68.00	06800	SPEECH PATHOLOGY	77,564	6,578	84,142	-84,142	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	201,095	201,095	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	670,772	77,810	748,582	0	748,582	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,064,904	275,859	1,340,763	-3,393	1,337,370	91.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,382,560	8,949,638	16,332,198	4,645	16,336,843	118.00
		NONREIMBURSABLE COST CENTERS						
190.02	19001	WORKPOWER/CORP HEALTH	0	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	30,033	30,033	-15,254	14,779	192.00
192.01	19201	VISTA MEDICAL CENTER EAST	0	0	0	9,119	9,119	192.01
194.00	07950	MARKETING	0	0	0	1,490	1,490	194.00
200.00		TOTAL (SUM OF LINES 118-199)	7,382,560	8,979,671	16,362,231	0	16,362,231	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet A | Date/Time Prepared: 4/28/2017 12:59 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	226,215	793,145		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	96,666	274,630		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	830,494		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,021,427	1,149,383		5.00
7.00	00700	OPERATION OF PLANT	298,030	1,781,444		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	154,360		8.00
9.00	00900	HOUSEKEEPING	771,853	771,853		9.00
10.00	01000	DIETARY	0	291,371		10.00
13.00	01300	NURSING ADMINISTRATION	-16	162,987		13.00
15.00	01500	PHARMACY	0	1,928		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-85	24,223		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	903,126		30.00
40.00	04000	SUBPROVIDER - IPF	0	1,528,149		40.00
41.00	04100	SUBPROVIDER - IRF	0	1,403,322		41.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	322,556		54.00
54.01	05401	ULTRA SOUND	0	0		54.01
57.00	05700	CT SCAN	0	0		57.00
60.00	06000	LABORATORY	-21,614	1,181,557		60.00
65.00	06500	RESPIRATORY THERAPY	0	14,537		65.00
66.00	06600	PHYSICAL THERAPY	0	810,353		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-26	201,069		73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0	748,582		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	21,492	1,358,862		91.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,628,912	14,707,931		118.00
		NONREIMBURSABLE COST CENTERS				
190.02	19001	WORKPOWER/CORP HEALTH	0	0		190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	14,779		192.00
192.01	19201	VISTA MEDICAL CENTER EAST	0	9,119		192.01
194.00	07950	MARKETING	0	1,490		194.00
200.00		TOTAL (SUM OF LINES 118-199)	-1,628,912	14,733,319		200.00

RECLASSIFICATIONS | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet A-6 | Date/Time Prepared: 4/28/2017 12:59 pm

		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	830,494		1.00
	TOTALS		0	830,494		
	C - RENT AND LEASE EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	46,563		1.00
2.00	OPERATION OF PLANT	7.00	0	1,979		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
	TOTALS		0	48,542		
	D - OTHER CAPITAL COSTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	75,088		1.00
	TOTALS		0	75,088		
	E - MARKETING DEPARTMENT					
1.00	MARKETING	194.00	0	1,490		1.00
	TOTALS		0	1,490		
	F - DRUGS AND IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	201,095		1.00
	TOTALS		0	201,095		
	G - PT, OT,SP COSTS					
1.00	PHYSICAL THERAPY	66.00	270,940	25,328		1.00
2.00		0.00	0	0		2.00
	TOTALS		270,940	25,328		
	H - OTHER RADIOLOGY COSTS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	196,864	89,984		1.00
2.00		0.00	0	0		2.00
	TOTALS		196,864	89,984		
	I - MOB COSTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,135		1.00
2.00	VISTA MEDICAL CENTER EAST	192.01	0	9,119		2.00
	TOTALS		0	15,254		
500.00	Grand Total: Increases		467,804	1,287,275		500.00

RECLASSIFICATIONS | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet A-6 | Date/Time Prepared: 4/28/2017 12:59 pm

	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	830,494	0		1.00
	TOTALS		0	830,494			
	C - RENT AND LEASE EXPENSE						
1.00	PHARMACY	15.00	0	23,643	10		1.00
2.00	SUBPROVIDER - IRF	41.00	0	1,951	0		2.00
3.00	LABORATORY	60.00	0	14,115	0		3.00
4.00	RESPIRATORY THERAPY	65.00	0	5,243	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	197	0		5.00
6.00	EMERGENCY	91.00	0	3,393	0		6.00
	TOTALS		0	48,542			
	D - OTHER CAPITAL COSTS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	75,088	13		1.00
	TOTALS		0	75,088			
	E - MARKETING DEPARTMENT						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,490	0		1.00
	TOTALS		0	1,490			
	F - DRUGS AND IV SOLUTIONS						
1.00	PHARMACY	15.00	0	201,095	0		1.00
	TOTALS		0	201,095			
	G - PT, OT,SP COSTS						
1.00	OCCUPATIONAL THERAPY	67.00	193,376	18,750	0		1.00
2.00	SPEECH PATHOLOGY	68.00	77,564	6,578	0		2.00
	TOTALS		270,940	25,328			
	H - OTHER RADIOLOGY COSTS						
1.00	ULTRA SOUND	54.01	14,024	9,990	0		1.00
2.00	CT SCAN	57.00	182,840	79,994	0		2.00
	TOTALS		196,864	89,984			
	I - MOB COSTS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	15,254	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	15,254			
500.00	Grand Total: Decreases		467,804	1,287,275			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet A-7 Part I | Date/Time Prepared: 4/28/2017 12:59 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	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	27,326,158	0	0	0	0	3.00
4.00	Building Improvements	3,131,021	8,542	0	8,542	0	4.00
5.00	Fixed Equipment	5,712,479	57,130	0	57,130	0	5.00
6.00	Movable Equipment	23,702,551	8,710	0	8,710	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	62,377,490	74,382	0	74,382	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	62,377,490	74,382	0	74,382	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	27,326,158	0	3.00
4.00	Building Improvements	3,139,563	0	4.00
5.00	Fixed Equipment	5,769,609	0	5.00
6.00	Movable Equipment	23,711,261	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	62,451,872	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	62,451,872	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet A-7 Part II | Date/Time Prepared: 4/28/2017 12:59 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	642,018	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	131,401	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	773,419	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	642,018		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	131,401		2.00
3.00	Total (sum of lines 1-2)	0	773,419		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet A-7 Part III Date/Time Prepared: 4/28/2017 12:59 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	32,971,002	0	32,971,002	0.527943	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	29,480,869	0	29,480,869	0.472057	0	2.00
3.00	Total (sum of lines 1-2)	62,451,871	0	62,451,871	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	169,798	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	228,067	46,563	2.00
3.00	Total (sum of lines 1-2)	0	0	0	397,865	46,563	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	698,435	0	-75,088	0	793,145	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	274,630	2.00
3.00	Total (sum of lines 1-2)	698,435	0	-75,088	0	1,067,775	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet A-8 | Date/Time Prepared: 4/28/2017 12:59 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-512,028			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	689,024			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	-26	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-85	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	B	-3,789	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	-457,059	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	57,835	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	RENTAL INCOME	B	-25,566	CAP REL COSTS-BLDG & FIXT	1.00	9	33.00
33.01	LOBBYING EXPENSE	A	-3,532	ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet A-8 | Date/Time Prepared: 4/28/2017 12:59 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	FITNESS REVENUE	B	-277	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	CARELINE REVENUE	B	-299	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	LEGAL FEES	A	-2,410	ADMINISTRATIVE & GENERAL	5.00	0	33.04
35.00	TRAINING REVENUE	B	-16	NURSING ADMINISTRATION	13.00	0	35.00
36.00	PHONE & TV DEPRECIATION	A	-1,185	CAP REL COSTS-MVBLE EQUIP	2.00	9	36.00
36.01	PHONE & TV	A	-16,388	ADMINISTRATIVE & GENERAL	5.00	0	36.01
37.00	STATE OPERATING TAX	A	-2,444,415	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	MISC REVENUE	B	-71	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	ALLOCATED SECURITY / PLANT OPS	A	298,030	OPERATION OF PLANT	7.00	0	39.00
40.00	ALLOCATED HOUSEKEEPING	A	771,853	HOUSEKEEPING	9.00	0	40.00
44.00	ALLOCATED EKG	A	21,492	EMERGENCY	91.00	0	44.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,628,912				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 12/01/2015 To 11/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 4/28/2017 12:59 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST EXPENSE	698,435	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	PASI OPERATING COSTS	112,950	49,365	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL	7,595	0	3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	2,810	0	4.00
4.01	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	38,824	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL HOME OFFICE COST	467,320	998,793	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE COST	92,995	0	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	ALLOCATION FROM VISTA EAST	140,069	0	4.04
4.05	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL	1,192	0	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	SHARED SERVICE CENTER ALLOCA	52,444	0	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	QHC SPECIFIC COSTS	122,548	0	4.07
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,737,182	1,048,158	5.00

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

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 4/28/2017 12:59 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	698,435	11		1.00
2.00	63,585	0		2.00
3.00	7,595	9		3.00
4.00	2,810	9		4.00
4.01	38,824	9		4.01
4.02	-531,473	0		4.02
4.03	92,995	0		4.03
4.04	140,069	0		4.04
4.05	1,192	9		4.05
4.06	52,444	0		4.06
4.07	122,548	0		4.07
5.00	689,024			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

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

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

6.00	HOME OFFICE		6.00
7.00			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 12/01/2015 To 11/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 4/28/2017 12:59 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	490,414	490,414	0	0	0	1.00
2.00	60.00	LABORATORY	21,614	21,614	0	0	0	2.00
3.00	0.00		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			512,028	512,028	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	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	0.00		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	490,414		1.00
2.00	60.00	LABORATORY	0	0	0	21,614		2.00
3.00	0.00		0	0	0	0		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	512,028		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet B Part I | Date/Time Prepared: 4/28/2017 12:59 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	793,145	793,145				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	274,630		274,630			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	830,494	0	0	830,494		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,149,383	29,598	10,248	20,435	1,209,664	5.00
7.00	00700	OPERATION OF PLANT	1,781,444	472,700	163,675	24,374	2,442,193	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	154,360	10,274	3,558	0	168,192	8.00
9.00	00900	HOUSEKEEPING	771,853	23,132	8,010	0	802,995	9.00
10.00	01000	DIETARY	291,371	6,153	2,130	0	299,654	10.00
13.00	01300	NURSING ADMINISTRATION	162,987	0	0	16,986	179,973	13.00
15.00	01500	PHARMACY	1,928	12,675	4,389	0	18,992	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	24,223	5,413	1,874	0	31,510	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	903,126	29,067	10,064	93,219	1,035,476	30.00
40.00	04000	SUBPROVIDER - IPF	1,528,149	42,474	14,707	154,955	1,740,285	40.00
41.00	04100	SUBPROVIDER - IRF	1,403,322	39,292	13,605	128,588	1,584,807	41.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	322,556	0	0	23,411	345,967	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
60.00	06000	LABORATORY	1,181,557	204	71	91,395	1,273,227	60.00
65.00	06500	RESPIRATORY THERAPY	14,537	0	0	0	14,537	65.00
66.00	06600	PHYSICAL THERAPY	810,353	18,349	6,353	81,878	916,933	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	201,069	0	0	0	201,069	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	748,582	17,300	5,990	75,458	847,330	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,358,862	53,463	18,512	119,795	1,550,632	91.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,707,931	760,094	263,186	830,494	14,663,436	118.00
		NONREIMBURSABLE COST CENTERS						
190.02	19001	WORKPOWER/CORP HEALTH	0	33,051	11,444	0	44,495	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,779	0	0	0	14,779	192.00
192.01	19201	VISTA MEDICAL CENTER EAST	9,119	0	0	0	9,119	192.01
194.00	07950	MARKETING	1,490	0	0	0	1,490	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	14,733,319	793,145	274,630	830,494	14,733,319	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet B Part I Date/Time Prepared: 4/28/2017 12:59 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,209,664					5.00
7.00	00700	OPERATION OF PLANT	218,450	2,660,643				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	15,044	93,989	277,225			8.00
9.00	00900	HOUSEKEEPING	71,826	211,612	0	1,086,433		9.00
10.00	01000	DIETARY	26,803	56,284	0	25,965	408,706	10.00
13.00	01300	NURSING ADMINISTRATION	16,098	0	0	0	0	13.00
15.00	01500	PHARMACY	1,699	115,949	0	53,490	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,819	49,522	0	22,846	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	92,621	265,900	44,119	122,666	0	30.00
40.00	04000	SUBPROVIDER - IPF	155,665	388,546	64,469	179,245	293,940	40.00
41.00	04100	SUBPROVIDER - IRF	141,758	359,438	59,638	165,817	110,965	41.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,946	0	0	0	0	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
60.00	06000	LABORATORY	113,888	1,868	0	862	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,300	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	82,018	167,854	27,850	77,435	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,985	0	0	0	0	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	75,792	158,259	0	73,008	3,801	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	138,701	489,073	81,149	225,618	0	91.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,203,413	2,358,294	277,225	946,952	408,706	118.00
		NONREIMBURSABLE COST CENTERS						
190.02	19001	WORKPOWER/CORP HEALTH	3,980	302,349	0	139,481	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,322	0	0	0	0	192.00
192.01	19201	VISTA MEDICAL CENTER EAST	816	0	0	0	0	192.01
194.00	07950	MARKETING	133	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,209,664	2,660,643	277,225	1,086,433	408,706	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet B Part I | Date/Time Prepared: 4/28/2017 12:59 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	196,071					13.00
15.00	01500	PHARMACY	0	190,130				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	106,697			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	9,191	1,569,973	0	30.00
40.00	04000	SUBPROVIDER - IPF	111,983	0	19,638	2,953,771	0	40.00
41.00	04100	SUBPROVIDER - IRF	84,088	0	8,598	2,515,109	0	41.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	14,060	390,973	0	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
60.00	06000	LABORATORY	0	0	9,185	1,399,030	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	100	15,937	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	7,582	1,279,672	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	190,130	6,684	415,868	0	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0	0	5,593	1,163,783	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	26,066	2,511,239	0	91.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	196,071	190,130	106,697	14,215,355	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.02	19001	WORKPOWER/CORP HEALTH	0	0	0	490,305	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	16,101	0	192.00
192.01	19201	VISTA MEDICAL CENTER EAST	0	0	0	9,935	0	192.01
194.00	07950	MARKETING	0	0	0	1,623	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	196,071	190,130	106,697	14,733,319	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet B Part I | Date/Time Prepared: 4/28/2017 12:59 pm

		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	1,569,973		30.00
40.00	04000	SUBPROVIDER - IPF	2,953,771		40.00
41.00	04100	SUBPROVIDER - IRF	2,515,109		41.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	390,973		54.00
54.01	05401	ULTRA SOUND	0		54.01
57.00	05700	CT SCAN	0		57.00
60.00	06000	LABORATORY	1,399,030		60.00
65.00	06500	RESPIRATORY THERAPY	15,937		65.00
66.00	06600	PHYSICAL THERAPY	1,279,672		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	415,868		73.00
76.00	03020	MENTAL HEALTH ANCILLARY	1,163,783		76.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	2,511,239		91.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,215,355		118.00
		NONREIMBURSABLE COST CENTERS			
190.02	19001	WORKPOWER/CORP HEALTH	490,305		190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	16,101		192.00
192.01	19201	VISTA MEDICAL CENTER EAST	9,935		192.01
194.00	07950	MARKETING	1,623		194.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	14,733,319		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet B Part II Date/Time Prepared: 4/28/2017 12:59 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	29,598	10,248	39,846	0	5.00
7.00	00700	OPERATION OF PLANT	0	472,700	163,675	636,375	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,274	3,558	13,832	0	8.00
9.00	00900	HOUSEKEEPING	0	23,132	8,010	31,142	0	9.00
10.00	01000	DIETARY	0	6,153	2,130	8,283	0	10.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
15.00	01500	PHARMACY	0	12,675	4,389	17,064	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,413	1,874	7,287	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	29,067	10,064	39,131	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	42,474	14,707	57,181	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	39,292	13,605	52,897	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
60.00	06000	LABORATORY	0	204	71	275	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	18,349	6,353	24,702	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0	17,300	5,990	23,290	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	53,463	18,512	71,975	0	91.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	760,094	263,186	1,023,280	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.02	19001	WORKPOWER/CORP HEALTH	0	33,051	11,444	44,495	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	VISTA 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				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	793,145	274,630	1,067,775	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet B Part II | Date/Time Prepared: 4/28/2017 12:59 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	39,846					5.00
7.00	00700	OPERATION OF PLANT	7,200	643,575				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	495	22,735	37,062			8.00
9.00	00900	HOUSEKEEPING	2,366	51,186	0	84,694		9.00
10.00	01000	DIETARY	883	13,614	0	2,024	24,804	10.00
13.00	01300	NURSING ADMINISTRATION	530	0	0	0	0	13.00
15.00	01500	PHARMACY	56	28,047	0	4,170	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	93	11,979	0	1,781	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,051	64,318	5,898	9,563	0	30.00
40.00	04000	SUBPROVIDER - IPF	5,127	93,984	8,619	13,973	17,839	40.00
41.00	04100	SUBPROVIDER - IRF	4,669	86,943	7,973	12,926	6,734	41.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,019	0	0	0	0	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
60.00	06000	LABORATORY	3,751	452	0	67	0	60.00
65.00	06500	RESPIRATORY THERAPY	43	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,701	40,602	3,723	6,037	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	592	0	0	0	0	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	2,496	38,281	0	5,691	231	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,568	118,300	10,849	17,589	0	91.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	39,640	570,441	37,062	73,821	24,804	118.00
		NONREIMBURSABLE COST CENTERS						
190.02	19001	WORKPOWER/CORP HEALTH	131	73,134	0	10,873	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	44	0	0	0	0	192.00
192.01	19201	VISTA MEDICAL CENTER EAST	27	0	0	0	0	192.01
194.00	07950	MARKETING	4	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	39,846	643,575	37,062	84,694	24,804	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet B Part II | Date/Time Prepared: 4/28/2017 12:59 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	530					13.00
15.00	01500	PHARMACY	0	49,337				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	21,140			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	1,819	123,780	0	30.00
40.00	04000	SUBPROVIDER - IPF	303	0	3,887	200,913	0	40.00
41.00	04100	SUBPROVIDER - IRF	227	0	1,702	174,071	0	41.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	2,783	3,802	0	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
60.00	06000	LABORATORY	0	0	1,818	6,363	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	20	63	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,501	79,266	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	49,337	1,323	51,252	0	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0	0	1,107	71,096	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	5,180	228,461	0	91.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	530	49,337	21,140	939,067	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.02	19001	WORKPOWER/CORP HEALTH	0	0	0	128,633	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	44	0	192.00
192.01	19201	VISTA MEDICAL CENTER EAST	0	0	0	27	0	192.01
194.00	07950	MARKETING	0	0	0	4	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	530	49,337	21,140	1,067,775	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet B Part II | Date/Time Prepared: 4/28/2017 12:59 pm

		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	123,780		30.00
40.00	04000	SUBPROVIDER - IPF	200,913		40.00
41.00	04100	SUBPROVIDER - IRF	174,071		41.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,802		54.00
54.01	05401	ULTRA SOUND	0		54.01
57.00	05700	CT SCAN	0		57.00
60.00	06000	LABORATORY	6,363		60.00
65.00	06500	RESPIRATORY THERAPY	63		65.00
66.00	06600	PHYSICAL THERAPY	79,266		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	51,252		73.00
76.00	03020	MENTAL HEALTH ANCILLARY	71,096		76.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	228,461		91.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	939,067		118.00
		NONREIMBURSABLE COST CENTERS			
190.02	19001	WORKPOWER/CORP HEALTH	128,633		190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	44		192.00
192.01	19201	VISTA MEDICAL CENTER EAST	27		192.01
194.00	07950	MARKETING	4		194.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	1,067,775		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet B-1 | Date/Time Prepared: 4/28/2017 12:59 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	225,337					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		225,337				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	7,382,560			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,409	8,409	181,658	-1,209,664	13,523,655	5.00
7.00	00700	OPERATION OF PLANT	134,297	134,297	216,667	0	2,442,193	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,919	2,919	0	0	168,192	8.00
9.00	00900	HOUSEKEEPING	6,572	6,572	0	0	802,995	9.00
10.00	01000	DIETARY	1,748	1,748	0	0	299,654	10.00
13.00	01300	NURSING ADMINISTRATION	0	0	150,995	0	179,973	13.00
15.00	01500	PHARMACY	3,601	3,601	0	0	18,992	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,538	1,538	0	0	31,510	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,258	8,258	828,660	0	1,035,476	30.00
40.00	04000	SUBPROVIDER - IPF	12,067	12,067	1,377,444	0	1,740,285	40.00
41.00	04100	SUBPROVIDER - IRF	11,163	11,163	1,143,064	0	1,584,807	41.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	208,109	0	345,967	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
60.00	06000	LABORATORY	58	58	812,444	0	1,273,227	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	14,537	65.00
66.00	06600	PHYSICAL THERAPY	5,213	5,213	727,843	0	916,933	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	201,069	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	4,915	4,915	670,772	0	847,330	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	15,189	15,189	1,064,904	0	1,550,632	91.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	215,947	215,947	7,382,560	-1,209,664	13,453,772	118.00
		NONREIMBURSABLE COST CENTERS						
190.02	19001	WORKPOWER/CORP HEALTH	9,390	9,390	0	0	44,495	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	14,779	192.00
192.01	19201	VISTA MEDICAL CENTER EAST	0	0	0	0	9,119	192.01
194.00	07950	MARKETING	0	0	0	0	1,490	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)	793,145	274,630	830,494		1,209,664	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.519817	1.218752	0.112494		0.089448	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		39,846	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.002946	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet B-1 | Date/Time Prepared: 4/28/2017 12:59 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRS G HR)	
			7.00	8.00	9.00	10.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	82,631					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,919	161,198				8.00
9.00	00900	HOUSEKEEPING	6,572	0	73,140			9.00
10.00	01000	DIETARY	1,748	0	1,748	37,307		10.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	77,817	13.00
15.00	01500	PHARMACY	3,601	0	3,601	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,538	0	1,538	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,258	25,654	8,258	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	12,067	37,487	12,067	26,831	44,444	40.00
41.00	04100	SUBPROVIDER - IRF	11,163	34,678	11,163	10,129	33,373	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
60.00	06000	LABORATORY	58	0	58	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,213	16,194	5,213	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	4,915	0	4,915	347	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 1-117)	73,241	161,198	63,750	37,307	77,817	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	VISTA MEDICAL CENTER EAST	0	0	0	0	0	192.01
194.00	07950	MARKETING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,660,643	277,225	1,086,433	408,706	196,071	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	32.199090	1.719779	14.854156	10.955209	2.519642	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	643,575	37,062	84,694	24,804	530	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.788542	0.229916	1.157971	0.664862	0.006811	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet B-1 | Date/Time Prepared: 4/28/2017 12:59 pm

		Cost Center Description	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			15.00	16.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
13.00	01300	NURSING ADMINISTRATION				13.00
15.00	01500	PHARMACY	201,095			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	110,559,641		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	9,524,801		30.00
40.00	04000	SUBPROVIDER - IPF	0	20,349,927		40.00
41.00	04100	SUBPROVIDER - IRF	0	8,910,192		41.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,570,303		54.00
54.01	05401	ULTRA SOUND	0	0		54.01
57.00	05700	CT SCAN	0	0		57.00
60.00	06000	LABORATORY	0	9,518,008		60.00
65.00	06500	RESPIRATORY THERAPY	0	103,142		65.00
66.00	06600	PHYSICAL THERAPY	0	7,856,983		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	201,095	6,926,325		73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0	5,795,860		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	27,004,100		91.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	201,095	110,559,641		118.00
		NONREIMBURSABLE COST CENTERS				
190.02	19001	WORKPOWER/CORP HEALTH	0	0		190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.01	19201	VISTA MEDICAL CENTER EAST	0	0		192.01
194.00	07950	MARKETING	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)	190,130	106,697		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.945474	0.000965		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	49,337	21,140		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.245342	0.000191		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet C Part I Date/Time Prepared: 4/28/2017 12:59 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,569,973		1,569,973	0	1,569,973	30.00
40.00	04000	SUBPROVIDER - IPF	2,953,771		2,953,771	0	2,953,771	40.00
41.00	04100	SUBPROVIDER - IRF	2,515,109		2,515,109	0	2,515,109	41.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	390,973		390,973	0	390,973	54.00
54.01	05401	ULTRA SOUND	0		0	0	0	54.01
57.00	05700	CT SCAN	0		0	0	0	57.00
60.00	06000	LABORATORY	1,399,030		1,399,030	0	1,399,030	60.00
65.00	06500	RESPIRATORY THERAPY	15,937	0	15,937	0	15,937	65.00
66.00	06600	PHYSICAL THERAPY	1,279,672	0	1,279,672	0	1,279,672	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	415,868		415,868	0	415,868	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	1,163,783		1,163,783	0	1,163,783	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,511,239		2,511,239	0	2,511,239	91.00
200.00		Subtotal (see instructions)	14,215,355	0	14,215,355	0	14,215,355	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	14,215,355	0	14,215,355	0	14,215,355	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet C Part I Date/Time Prepared: 4/28/2017 12:59 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,524,801		9,524,801			30.00
40.00	04000	SUBPROVIDER - IPF	20,349,927		20,349,927			40.00
41.00	04100	SUBPROVIDER - IRF	8,910,192		8,910,192			41.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	399,601	14,170,702	14,570,303	0.026834	0.000000	54.00
54.01	05401	ULTRA SOUND	0	0	0	0.000000	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
60.00	06000	LABORATORY	2,027,234	7,490,774	9,518,008	0.146988	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	304	102,838	103,142	0.154515	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	7,856,983	0	7,856,983	0.162871	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,706,780	2,219,545	6,926,325	0.060042	0.000000	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	430,265	5,365,595	5,795,860	0.200796	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,673,272	24,330,828	27,004,100	0.092995	0.000000	91.00
200.00		Subtotal (see instructions)	56,879,359	53,680,282	110,559,641			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	56,879,359	53,680,282	110,559,641			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet C Part I Date/Time Prepared: 4/28/2017 12:59 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.026834		54.00
54.01	05401	ULTRA SOUND	0.000000		54.01
57.00	05700	CT SCAN	0.000000		57.00
60.00	06000	LABORATORY	0.146988		60.00
65.00	06500	RESPIRATORY THERAPY	0.154515		65.00
66.00	06600	PHYSICAL THERAPY	0.162871		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.060042		73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0.200796		76.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.092995		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 12/01/2015 To 11/30/2016 | Worksheet C Part I Date/Time Prepared: 4/28/2017 12:59 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,569,973		1,569,973	0	1,569,973	30.00
40.00	04000	SUBPROVIDER - IPF	2,953,771		2,953,771	0	2,953,771	40.00
41.00	04100	SUBPROVIDER - IRF	2,515,109		2,515,109	0	2,515,109	41.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	390,973		390,973	0	390,973	54.00
54.01	05401	ULTRA SOUND	0		0	0	0	54.01
57.00	05700	CT SCAN	0		0	0	0	57.00
60.00	06000	LABORATORY	1,399,030		1,399,030	0	1,399,030	60.00
65.00	06500	RESPIRATORY THERAPY	15,937	0	15,937	0	15,937	65.00
66.00	06600	PHYSICAL THERAPY	1,279,672	0	1,279,672	0	1,279,672	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	415,868		415,868	0	415,868	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	1,163,783		1,163,783	0	1,163,783	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,511,239		2,511,239	0	2,511,239	91.00
200.00		Subtotal (see instructions)	14,215,355	0	14,215,355	0	14,215,355	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	14,215,355	0	14,215,355	0	14,215,355	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet C Part I Date/Time Prepared: 4/28/2017 12:59 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,524,801		9,524,801			30.00
40.00	04000	SUBPROVIDER - IPF	20,349,927		20,349,927			40.00
41.00	04100	SUBPROVIDER - IRF	8,910,192		8,910,192			41.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	399,601	14,170,702	14,570,303	0.026834	0.000000	54.00
54.01	05401	ULTRA SOUND	0	0	0	0.000000	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
60.00	06000	LABORATORY	2,027,234	7,490,774	9,518,008	0.146988	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	304	102,838	103,142	0.154515	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	7,856,983	0	7,856,983	0.162871	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,706,780	2,219,545	6,926,325	0.060042	0.000000	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	430,265	5,365,595	5,795,860	0.200796	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,673,272	24,330,828	27,004,100	0.092995	0.000000	91.00
200.00		Subtotal (see instructions)	56,879,359	53,680,282	110,559,641			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	56,879,359	53,680,282	110,559,641			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet C Part I Date/Time Prepared: 4/28/2017 12:59 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.026834		54.00
54.01	05401	ULTRA SOUND	0.000000		54.01
57.00	05700	CT SCAN	0.000000		57.00
60.00	06000	LABORATORY	0.146988		60.00
65.00	06500	RESPIRATORY THERAPY	0.154515		65.00
66.00	06600	PHYSICAL THERAPY	0.162871		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.060042		73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0.200796		76.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.092995		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 12/01/2015 To 11/30/2016 | Worksheet C Part II | Date/Time Prepared: 4/28/2017 12:59 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	390,973	3,802	387,171	0	0	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
60.00	06000	LABORATORY	1,399,030	6,363	1,392,667	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	15,937	63	15,874	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,279,672	79,266	1,200,406	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	415,868	51,252	364,616	0	0	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	1,163,783	71,096	1,092,687	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,511,239	228,461	2,282,778	0	0	91.00
200.00		Subtotal (sum of lines 50 thru 199)	7,176,502	440,303	6,736,199	0	0	200.00
201.00		Less Observation Beds	0	0	0	0	0	201.00
202.00		Total (line 200 minus line 201)	7,176,502	440,303	6,736,199	0	0	202.00

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

Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet C Part II | Date/Time Prepared: 4/28/2017 12:59 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	390,973	14,570,303	0.026834		54.00
54.01	05401	ULTRA SOUND	0	0	0.000000		54.01
57.00	05700	CT SCAN	0	0	0.000000		57.00
60.00	06000	LABORATORY	1,399,030	9,518,008	0.146988		60.00
65.00	06500	RESPIRATORY THERAPY	15,937	103,142	0.154515		65.00
66.00	06600	PHYSICAL THERAPY	1,279,672	7,856,983	0.162871		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000		68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	415,868	6,926,325	0.060042		73.00
76.00	03020	MENTAL HEALTH ANCILLARY	1,163,783	5,795,860	0.200796		76.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	2,511,239	27,004,100	0.092995		91.00
200.00		Subtotal (sum of lines 50 thru 199)	7,176,502	71,774,721			200.00
201.00		Less Observation Beds	0	0			201.00
202.00		Total (line 200 minus line 201)	7,176,502	71,774,721			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet D Part I | Date/Time Prepared: 4/28/2017 12:59 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	123,780	0	123,780	2,698	45.88	30.00
40.00	SUBPROVIDER - IPF	200,913	0	200,913	5,760	34.88	40.00
41.00	SUBPROVIDER - IRF	174,071	0	174,071	3,345	52.04	41.00
200.00	Total (lines 30-199)	498,764		498,764	11,803		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	8	367		30.00
40.00	SUBPROVIDER - IPF	1,065	37,147		40.00
41.00	SUBPROVIDER - IRF	2,118	110,221		41.00
200.00	Total (lines 30-199)	3,191	147,735		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet D Part II Date/Time Prepared: 4/28/2017 12:59 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,802	14,570,303	0.000261	775	0	54.00
54.01	05401	ULTRA SOUND	0	0	0.000000	0	0	54.01
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
60.00	06000	LABORATORY	6,363	9,518,008	0.000669	2,275	2	60.00
65.00	06500	RESPIRATORY THERAPY	63	103,142	0.000611	0	0	65.00
66.00	06600	PHYSICAL THERAPY	79,266	7,856,983	0.010089	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	51,252	6,926,325	0.007400	3,172	23	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	71,096	5,795,860	0.012267	528	6	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	228,461	27,004,100	0.008460	5,691	48	91.00
200.00		Total (lines 50-199)	440,303	71,774,721		12,441	79	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet D Part III Date/Time Prepared: 4/28/2017 12:59 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,698	0.00	8	0		30.00
40.00	04000	SUBPROVIDER - IPF	5,760	0.00	1,065	0		40.00
41.00	04100	SUBPROVIDER - IRF	3,345	0.00	2,118	0		41.00
200.00		Total (lines 30-199)	11,803		3,191	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet D Part IV | Date/Time Prepared: 4/28/2017 12:59 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet D Part IV | Date/Time Prepared: 4/28/2017 12:59 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,570,303	0.000000	0.000000	775	54.00
54.01	05401	ULTRA SOUND	0	0	0.000000	0.000000	0	54.01
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
60.00	06000	LABORATORY	0	9,518,008	0.000000	0.000000	2,275	60.00
65.00	06500	RESPIRATORY THERAPY	0	103,142	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	7,856,983	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,926,325	0.000000	0.000000	3,172	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0	5,795,860	0.000000	0.000000	528	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	27,004,100	0.000000	0.000000	5,691	91.00
200.00		Total (lines 50-199)	0	71,774,721			12,441	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet D Part IV | Date/Time Prepared: 4/28/2017 12:59 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,011,386	0		54.00
54.01	05401	ULTRA SOUND	0	0	0		54.01
57.00	05700	CT SCAN	0	0	0		57.00
60.00	06000	LABORATORY	0	397,752	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	5,156	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	148,768	0		73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0	252,087	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	1,730,595	0		91.00
200.00		Total (lines 50-199)	0	3,545,744	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet D Part V Date/Time Prepared: 4/28/2017 12:59 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.026834	1,011,386	0	0	27,140	54.00
54.01	05401	ULTRA SOUND	0.000000	0	0	0	0	54.01
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
60.00	06000	LABORATORY	0.146988	397,752	0	0	58,465	60.00
65.00	06500	RESPIRATORY THERAPY	0.154515	5,156	0	0	797	65.00
66.00	06600	PHYSICAL THERAPY	0.162871	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.060042	148,768	0	0	8,932	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0.200796	252,087	0	0	50,618	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.092995	1,730,595	0	0	160,937	91.00
200.00		Subtotal (see instructions)		3,545,744	0	0	306,889	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		3,545,744	0	0	306,889	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet D Part V Date/Time Prepared: 4/28/2017 12:59 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRA SOUND	0	0		54.01
57.00	05700	CT SCAN	0	0		57.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0033 | Component CCN: 14-S033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet D Part II | Date/Time Prepared: 4/28/2017 12:59 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,802	14,570,303	0.000261	83,551	22	54.00
54.01	05401	ULTRA SOUND	0	0	0.000000	0	0	54.01
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
60.00	06000	LABORATORY	6,363	9,518,008	0.000669	209,683	140	60.00
65.00	06500	RESPIRATORY THERAPY	63	103,142	0.000611	0	0	65.00
66.00	06600	PHYSICAL THERAPY	79,266	7,856,983	0.010089	2,282	23	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	51,252	6,926,325	0.007400	548,434	4,058	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	71,096	5,795,860	0.012267	50,953	625	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	228,461	27,004,100	0.008460	306,539	2,593	91.00
200.00		Total (lines 50-199)	440,303	71,774,721		1,201,442	7,461	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0033
Component CCN: 14-S033
Period: From 12/01/2015 To 11/30/2016
Worksheet D Part IV
Date/Time Prepared: 4/28/2017 12:59 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0033 | Component CCN: 14-S033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet D Part IV | Date/Time Prepared: 4/28/2017 12:59 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,570,303	0.000000	0.000000	83,551	54.00
54.01	05401	ULTRA SOUND	0	0	0.000000	0.000000	0	54.01
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
60.00	06000	LABORATORY	0	9,518,008	0.000000	0.000000	209,683	60.00
65.00	06500	RESPIRATORY THERAPY	0	103,142	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	7,856,983	0.000000	0.000000	2,282	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,926,325	0.000000	0.000000	548,434	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0	5,795,860	0.000000	0.000000	50,953	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	27,004,100	0.000000	0.000000	306,539	91.00
200.00		Total (lines 50-199)	0	71,774,721			1,201,442	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0033 | Component CCN: 14-S033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet D Part IV | Date/Time Prepared: 4/28/2017 12:59 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05401	ULTRA SOUND	0	0	0		54.01
57.00	05700	CT SCAN	0	0	0		57.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0	83,619	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	2,620	0		91.00
200.00		Total (lines 50-199)	0	86,239	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0033
Component CCN: 14-S033
Period: From 12/01/2015 To 11/30/2016
Worksheet D Part V
Date/Time Prepared: 4/28/2017 12:59 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.026834	0	0	0	0	54.00
54.01	05401	ULTRA SOUND	0.000000	0	0	0	0	54.01
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
60.00	06000	LABORATORY	0.146988	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.154515	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.162871	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.060042	0	94	0	0	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0.200796	83,619	0	0	16,790	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.092995	2,620	0	0	244	91.00
200.00		Subtotal (see instructions)		86,239	94	0	17,034	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		86,239	94	0	17,034	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0033 | Component CCN: 14-S033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet D Part V | Date/Time Prepared: 4/28/2017 12:59 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRA SOUND	0	0		54.01
57.00	05700	CT SCAN	0	0		57.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6	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)	6	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	6	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0033 | Component CCN: 14-T033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet D Part II | Date/Time Prepared: 4/28/2017 12:59 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	3,802	14,570,303	0.000261	143,258	37	54.00
54.01	05401	ULTRA SOUND	0	0	0.000000	0	0	54.01
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
60.00	06000	LABORATORY	6,363	9,518,008	0.000669	490,384	328	60.00
65.00	06500	RESPIRATORY THERAPY	63	103,142	0.000611	0	0	65.00
66.00	06600	PHYSICAL THERAPY	79,266	7,856,983	0.010089	4,890,091	49,336	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	51,252	6,926,325	0.007400	1,328,915	9,834	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	71,096	5,795,860	0.012267	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	228,461	27,004,100	0.008460	283,190	2,396	91.00
200.00		Total (lines 50-199)	440,303	71,774,721		7,135,838	61,931	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0033
Component CCN: 14-T033

Period:
From 12/01/2015
To 11/30/2016

Worksheet D
Part IV
Date/Time Prepared:
4/28/2017 12:59 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0033 | Component CCN: 14-T033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet D Part IV | Date/Time Prepared: 4/28/2017 12:59 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,570,303	0.000000	0.000000	143,258	54.00
54.01	05401	ULTRA SOUND	0	0	0.000000	0.000000	0	54.01
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
60.00	06000	LABORATORY	0	9,518,008	0.000000	0.000000	490,384	60.00
65.00	06500	RESPIRATORY THERAPY	0	103,142	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	7,856,983	0.000000	0.000000	4,890,091	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,926,325	0.000000	0.000000	1,328,915	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0	5,795,860	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	27,004,100	0.000000	0.000000	283,190	91.00
200.00		Total (lines 50-199)	0	71,774,721			7,135,838	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0033 Component CCN: 14-T033	Period: From 12/01/2015 To 11/30/2016	Worksheet D Part IV Date/Time Prepared: 4/28/2017 12:59 pm
	Title XVIII	Subprovider - IRF	PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	775	0		54.00
54.01	05401	ULTRA SOUND	0	0	0		54.01
57.00	05700	CT SCAN	0	0	0		57.00
60.00	06000	LABORATORY	0	841	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	263	0		91.00
200.00		Total (lines 50-199)	0	1,879	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0033
Component CCN: 14-T033
Period: From 12/01/2015 To 11/30/2016
Worksheet D Part V
Date/Time Prepared: 4/28/2017 12:59 pm
Title XVIII
Subprovider - IRF
PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.026834	775	0	0	21	54.00
54.01	05401	ULTRA SOUND	0.000000	0	0	0	0	54.01
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
60.00	06000	LABORATORY	0.146988	841	0	0	124	60.00
65.00	06500	RESPIRATORY THERAPY	0.154515	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.162871	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.060042	0	94	0	0	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0.200796	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.092995	263	0	0	24	91.00
200.00		Subtotal (see instructions)		1,879	94	0	169	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		1,879	94	0	169	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0033
Component CCN: 14-T033
Period: From 12/01/2015 To 11/30/2016
Worksheet D Part V
Date/Time Prepared: 4/28/2017 12:59 pm
Title XVIII
Subprovider - IRF
PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRA SOUND	0	0		54.01
57.00	05700	CT SCAN	0	0		57.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6	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)	6	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	6	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet D Part I | Date/Time Prepared: 4/28/2017 12:59 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	123,780	0	123,780	2,698	45.88	30.00
40.00	SUBPROVIDER - IPF	200,913	0	200,913	5,760	34.88	40.00
41.00	SUBPROVIDER - IRF	174,071	0	174,071	3,345	52.04	41.00
200.00	Total (lines 30-199)	498,764		498,764	11,803		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,035	93,366				30.00
40.00	SUBPROVIDER - IPF	3,110	108,477				40.00
41.00	SUBPROVIDER - IRF	332	17,277				41.00
200.00	Total (lines 30-199)	5,477	219,120				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet D Part II Date/Time Prepared: 4/28/2017 12:59 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,802	14,570,303	0.000261	0	0	54.00
54.01	05401	ULTRA SOUND	0	0	0.000000	0	0	54.01
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
60.00	06000	LABORATORY	6,363	9,518,008	0.000669	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	63	103,142	0.000611	0	0	65.00
66.00	06600	PHYSICAL THERAPY	79,266	7,856,983	0.010089	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	51,252	6,926,325	0.007400	0	0	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	71,096	5,795,860	0.012267	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	228,461	27,004,100	0.008460	0	0	91.00
200.00		Total (lines 50-199)	440,303	71,774,721		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet D Part III Date/Time Prepared: 4/28/2017 12:59 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,698	0.00	2,035	0		30.00
40.00	04000	SUBPROVIDER - IPF	5,760	0.00	3,110	0		40.00
41.00	04100	SUBPROVIDER - IRF	3,345	0.00	332	0		41.00
200.00		Total (lines 30-199)	11,803		5,477	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet D Part IV | Date/Time Prepared: 4/28/2017 12:59 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet D Part IV Date/Time Prepared: 4/28/2017 12:59 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,570,303	0.000000	0.000000	0	54.00
54.01	05401	ULTRA SOUND	0	0	0.000000	0.000000	0	54.01
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
60.00	06000	LABORATORY	0	9,518,008	0.000000	0.000000	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	103,142	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	7,856,983	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,926,325	0.000000	0.000000	0	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0	5,795,860	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	27,004,100	0.000000	0.000000	0	91.00
200.00		Total (lines 50-199)	0	71,774,721			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet D Part IV | Date/Time Prepared: 4/28/2017 12:59 pm

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05401	ULTRA SOUND	0	0	0		54.01
57.00	05700	CT SCAN	0	0	0		57.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	0		91.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet D-1 | Date/Time Prepared: 4/28/2017 12:59 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,698	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,698	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,698	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)	8	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)	1,569,973	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)	1,569,973	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)	1,569,973	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)	581.90	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,655	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)	4,655	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet D-1 | Date/Time Prepared: 4/28/2017 12:59 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)	1,180	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,835	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)	367	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	79	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	446	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	5,389	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 12/01/2015 To 11/30/2016 | Worksheet D-1 | Date/Time Prepared: 4/28/2017 12:59 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	123,780	1,569,973	0.078842	0	0	90.00
91.00	Nursing School cost	0	1,569,973	0.000000	0	0	91.00
92.00	Allied health cost	0	1,569,973	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,569,973	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0033 Component CCN: 14-S033	Period: From 12/01/2015 To 11/30/2016	Worksheet D-1 Date/Time Prepared: 4/28/2017 12:59 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,760	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,760	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,760	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,065	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)	2,953,771	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,953,771	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)	2,953,771	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)	512.81	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	546,143	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)	546,143	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0033 | Component CCN: 14-S033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet D-1 | Date/Time Prepared: 4/28/2017 12:59 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)	105,102	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	651,245	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)	37,147	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	7,461	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	44,608	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	606,637	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 12/01/2015 To 11/30/2016 | Worksheet D-1 | Date/Time Prepared: 4/28/2017 12:59 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	200,913	2,953,771	0.068019	0	0	90.00
91.00	Nursing School cost	0	2,953,771	0.000000	0	0	91.00
92.00	Allied health cost	0	2,953,771	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,953,771	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0033 Component CCN: 14-T033	Period: From 12/01/2015 To 11/30/2016	Worksheet D-1 Date/Time Prepared: 4/28/2017 12:59 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)	3,345	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,345	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,345	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,118	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)	2,515,109	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,515,109	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)	2,515,109	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)	751.90	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,592,524	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,592,524	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0033 | Component CCN: 14-T033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet D-1 | Date/Time Prepared: 4/28/2017 12:59 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)	978,505	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,571,029	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)	110,221	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	61,931	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	172,152	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,398,877	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 12/01/2015 To 11/30/2016 | Worksheet D-1 | Date/Time Prepared: 4/28/2017 12:59 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	174,071	2,515,109	0.069210	0	0	90.00
91.00	Nursing School cost	0	2,515,109	0.000000	0	0	91.00
92.00	Allied health cost	0	2,515,109	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,515,109	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet D-1 | Date/Time Prepared: 4/28/2017 12:59 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,698	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,698	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,698	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,035	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)	1,569,973	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)	1,569,973	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)	1,569,973	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)	581.90	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,184,167	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,184,167	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet D-1 | Date/Time Prepared: 4/28/2017 12:59 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)	1,184,167	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)	93,366	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)	93,366	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,090,801	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 12/01/2015 To 11/30/2016 | Worksheet D-1 | Date/Time Prepared: 4/28/2017 12:59 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	123,780	1,569,973	0.078842	0	0	90.00
91.00	Nursing School cost	0	1,569,973	0.000000	0	0	91.00
92.00	Allied health cost	0	1,569,973	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,569,973	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet D-3 | Date/Time Prepared: 4/28/2017 12:59 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		28,584		30.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.026834	775	21	54.00
54.01	05401	ULTRA SOUND	0.000000	0	0	54.01
57.00	05700	CT SCAN	0.000000	0	0	57.00
60.00	06000	LABORATORY	0.146988	2,275	334	60.00
65.00	06500	RESPIRATORY THERAPY	0.154515	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.162871	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.060042	3,172	190	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0.200796	528	106	76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.092995	5,691	529	91.00
200.00		Total (sum of lines 50-94 and 96-98)		12,441	1,180	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		12,441		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0033 | Component CCN: 14-S033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet D-3 | Date/Time Prepared: 4/28/2017 12:59 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
40.00	04000	SUBPROVIDER - IPF		3,750,330		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.026834	83,551	2,242	54.00
54.01	05401	ULTRA SOUND	0.000000	0	0	54.01
57.00	05700	CT SCAN	0.000000	0	0	57.00
60.00	06000	LABORATORY	0.146988	209,683	30,821	60.00
65.00	06500	RESPIRATORY THERAPY	0.154515	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.162871	2,282	372	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.060042	548,434	32,929	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0.200796	50,953	10,231	76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.092995	306,539	28,507	91.00
200.00		Total (sum of lines 50-94 and 96-98)		1,201,442	105,102	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,201,442		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0033 | Component CCN: 14-T033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet D-3 | Date/Time Prepared: 4/28/2017 12:59 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		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		5,625,134		41.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.026834	143,258	3,844	54.00
54.01	05401	ULTRA SOUND	0.000000	0	0	54.01
57.00	05700	CT SCAN	0.000000	0	0	57.00
60.00	06000	LABORATORY	0.146988	490,384	72,081	60.00
65.00	06500	RESPIRATORY THERAPY	0.154515	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.162871	4,890,091	796,454	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.060042	1,328,915	79,791	73.00
76.00	03020	MENTAL HEALTH ANCILLARY	0.200796	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.092995	283,190	26,335	91.00
200.00		Total (sum of lines 50-94 and 96-98)		7,135,838	978,505	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		7,135,838		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0033	Period: From 12/01/2015 To 11/30/2016	Worksheet E Part A Date/Time Prepared: 4/28/2017 12:59 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	4,961	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	992	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	0	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	16.00	4.00
	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 Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
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)	17.39	30.00
31.00	Percentage of Medicaid patient days (see instructions)	75.43	31.00
32.00	Sum of lines 30 and 31	92.82	32.00
33.00	Allowable disproportionate share percentage (see instructions)	12.00	33.00
34.00	Disproportionate share adjustment (see instructions)	179	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet E Part A Date/Time Prepared: 4/28/2017 12:59 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)	6,406,145,534	5,977,483,147	35.00
35.01	Factor 3 (see instructions)	0.000066901	0.000066772	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	428,578	399,129	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	357,148	66,704	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	423,852		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 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 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 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	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)	429,984		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)		429,984	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		477	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 intructions)		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)		430,461	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		430,461	61.00
62.00	Deductibles billed to program beneficiaries		1,288	62.00
63.00	Coinsurance billed to program beneficiaries		0	63.00
64.00	Allowable bad debts (see instructions)		0	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		0	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		429,173	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	ADJUSTMENT FOR CORRECTION TO CLAIMS		-424,031	70.00
70.50	RURAL DEMONSTRATION PROJECT		0	70.50
70.88	SCH or MDH volume decrease adjustment		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		0	70.93
70.94	HRR adjustment amount (see instructions)		0	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0033	Period: From 12/01/2015 To 11/30/2016	Worksheet E Part A Date/Time Prepared: 4/28/2017 12:59 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)		5,142	71.00
71.01	Sequestration adjustment (see instructions)		103	71.01
72.00	Interim payments		24,306	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		-19,267	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		64,978	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0033	Period: From 12/01/2015 To 11/30/2016	Worksheet E Part B Date/Time Prepared: 4/28/2017 12:59 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	306,889	2.00
3.00	PPS payments	304,659	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	304,659	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	65,924	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)	238,735	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)	238,735	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	238,735	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)	26,733	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	17,376	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	17,895	36.00
37.00	Subtotal (see instructions)	256,111	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	256,111	40.00
40.01	Sequestration adjustment (see instructions)	5,122	40.01
41.00	Interim payments	233,959	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	17,030	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0033 Component CCN: 14-S033	Period: From 12/01/2015 To 11/30/2016	Worksheet E Part B Date/Time Prepared: 4/28/2017 12:59 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	17,034	2.00
3.00	PPS payments	11,536	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	6	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	94	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)	94	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	94	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	88	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	6	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	11,536	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,301	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)	9,241	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)	9,241	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	9,241	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	9,241	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	9,241	40.00
40.01	Sequestration adjustment (see instructions)	185	40.01
41.00	Interim payments	9,069	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-13	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0033 Component CCN: 14-T033	Period: From 12/01/2015 To 11/30/2016	Worksheet E Part B Date/Time Prepared: 4/28/2017 12:59 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	169	2.00
3.00	PPS payments	241	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	6	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	94	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)	94	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	94	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	88	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	6	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	241	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	42	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)	205	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)	205	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	205	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	205	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	205	40.00
40.01	Sequestration adjustment (see instructions)	4	40.01
41.00	Interim payments	213	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-12	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 12/01/2015 To 11/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 4/28/2017 12:59 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		24,306		233,959	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)		24,306		233,959	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		17,030	6.01
6.02	SETTLEMENT TO PROGRAM		19,267		0	6.02
7.00	Total Medicare program liability (see instructions)		5,039		250,989	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 12/01/2015 To 11/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 4/28/2017 12:59 pm

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		860,648		9,069	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)		860,648		9,069	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		33,701		13	6.02
7.00	Total Medicare program liability (see instructions)		826,947		9,056	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0033 | Component CCN: 14-T033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 4/28/2017 12:59 pm

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,123,538		213	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)		3,123,538		213	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		2,299		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		12	6.02
7.00	Total Medicare program liability (see instructions)		3,125,837		201	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 12/01/2015 To 11/30/2016	Worksheet E-1 Part II Date/Time Prepared: 4/28/2017 12:59 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	443	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	8	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	18	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	2,698	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	110,559,641	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	560,743	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	9,700	8.00
9.00	Sequestration adjustment amount (see instructions)	194	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	9,506	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	9,506	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0033 Component CCN: 14-S033	Period: From 12/01/2015 To 11/30/2016	Worksheet E-3 Part II Date/Time Prepared: 4/28/2017 12:59 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	932,165	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 instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	15.737705	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	932,165	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)	932,165	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	932,165	18.00
19.00	Deductibles	125,804	19.00
20.00	Subtotal (line 18 minus line 19)	806,361	20.00
21.00	Coinsurance	20,608	21.00
22.00	Subtotal (line 20 minus line 21)	785,753	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	89,339	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	58,070	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	67,700	25.00
26.00	Subtotal (sum of lines 22 and 24)	843,823	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	843,823	31.00
31.01	Sequestration adjustment (see instructions)	16,876	31.01
32.00	Interim payments	860,648	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	-33,701	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	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 12/01/2015 To 11/30/2016	Worksheet E-3 Part III Date/Time Prepared: 4/28/2017 12:59 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	3,050,177	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0397	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	128,717	3.00
4.00	Outlier Payments	18,090	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	9.139344	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)	3,196,984	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)	3,196,984	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	3,196,984	19.00
20.00	Deductibles	5,152	20.00
21.00	Subtotal (line 19 minus line 20)	3,191,832	21.00
22.00	Coinsurance	10,304	22.00
23.00	Subtotal (line 21 minus line 22)	3,181,528	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	12,465	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	8,102	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)	3,189,630	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Recovery of Accelerated Depreciation	0	31.99
32.00	Total amount payable to the provider (see instructions)	3,189,630	32.00
32.01	Sequestration adjustment (see instructions)	63,793	32.01
33.00	Interim payments	3,123,538	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 33, and 34)	2,299	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	5,185	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	18,090	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 12/01/2015 To 11/30/2016 | Worksheet G | Date/Time Prepared: 4/28/2017 12:59 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-1,043	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	6,626,068	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,944,812	0	0	0	6.00
7.00	Inventory	221,499	0	0	0	7.00
8.00	Prepaid expenses	30,582	0	0	0	8.00
9.00	Other current assets	41,009	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	4,973,303	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	-2,431,583	0	0	0	14.00
15.00	Buildings	13,181,395	0	0	0	15.00
16.00	Accumulated depreciation	-3,636,618	0	0	0	16.00
17.00	Leasehold improvements	1,256,060	0	0	0	17.00
18.00	Accumulated depreciation	-791,642	0	0	0	18.00
19.00	Fixed equipment	1,324,516	0	0	0	19.00
20.00	Accumulated depreciation	-554,773	0	0	0	20.00
21.00	Automobiles and trucks	22,569	0	0	0	21.00
22.00	Accumulated depreciation	-22,569	0	0	0	22.00
23.00	Major movable equipment	2,174,167	0	0	0	23.00
24.00	Accumulated depreciation	-2,096,038	0	0	0	24.00
25.00	Minor equipment depreciable	1,389,960	0	0	0	25.00
26.00	Accumulated depreciation	-1,363,109	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)	16,973,704	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	-188,902	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	-188,902	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	21,758,105	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,759,644	0	0	0	37.00
38.00	Salaries, wages, and fees payable	740,363	0	0	0	38.00
39.00	Payroll taxes payable	77,149	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				42.00
43.00	Due to other funds	-3,178,795	0	0	0	43.00
44.00	Other current liabilities	798,603	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	196,964	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)	196,964	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	21,561,141				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)	21,561,141	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	21,758,105	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0033 | Period: From 12/01/2015 To 11/30/2016 | Worksheet G-1 | Date/Time Prepared: 4/28/2017 12:59 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		16,684,773		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4,876,361				2.00
3.00	Total (sum of line 1 and line 2)		21,561,134		0		3.00
4.00	ROUNDING	7		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		7		0		10.00
11.00	Subtotal (line 3 plus line 10)		21,561,141		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		21,561,141		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 12/01/2015 To 11/30/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 4/28/2017 12:59 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	9,524,801		9,524,801	1.00
2.00	SUBPROVIDER - IPF	20,349,927		20,349,927	2.00
3.00	SUBPROVIDER - IRF	8,910,192		8,910,192	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)	38,784,920		38,784,920	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)	38,784,920		38,784,920	17.00
18.00	Ancillary services	15,421,167	29,349,454	44,770,621	18.00
19.00	Outpatient services	2,673,272	24,330,828	27,004,100	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)	56,879,359	53,680,282	110,559,641	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		16,362,231		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)		16,362,231		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-0033	Period: From 12/01/2015 To 11/30/2016	Worksheet G-3 Date/Time Prepared: 4/28/2017 12:59 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	110,559,641	1.00
2.00	Less contractual allowances and discounts on patients' accounts	89,360,238	2.00
3.00	Net patient revenues (line 1 minus line 2)	21,199,403	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	16,362,231	4.00
5.00	Net income from service to patients (line 3 minus line 4)	4,837,172	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	39,189	24.00
25.00	Total other income (sum of lines 6-24)	39,189	25.00
26.00	Total (line 5 plus line 25)	4,876,361	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)	4,876,361	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0033	Period: From 12/01/2015 To 11/30/2016	Worksheet L Parts I-III Date/Time Prepared: 4/28/2017 12:59 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	477	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)	7.37	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)	477	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