

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0084	Period: From 12/01/2017 To 11/30/2018	Worksheet S Parts I-III Date/Time Prepared: 4/29/2019 2:06 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 4/29/2019	Time: 2:06 pm
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by VISTA MEDICAL CENTER - EAST (14-0084) for the cost reporting period beginning 12/01/2017 and ending 11/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) DONALD BIVACCA

Officer or Administrator of Provider(s)

CFO

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	410,416	-95,247	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
200.00	Total	0	410,416	-95,247	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0084		Period: From 12/01/2017 To 11/30/2018		Worksheet S-2 Part I Date/Time Prepared: 4/29/2019 2:06 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 1324 NORTH SHERIDAN ROAD			PO Box:				1.00	
2.00	City: WAUKEGAN			State: IL		Zip Code: 60085-		County: LAKE	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			VISTA MEDICAL CENTER - EAST	140084	29404	1	07/01/1966	N
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						12/01/2017	11/30/2018	20.00
21.00	Type of Control (see instructions)						4		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	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.			1,930	0	0	0	12,302	0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0084

Period:
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		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
						Urban/Rural S	Date of Geogr	
						1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
						Beginning:	Ending:	
						1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
						Y/N	Y/N	
						1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
						V	XVIII	XIX
						1.00	2.00	3.00
Prospective Payment System (PPS)-Capital								
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	Y	N
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
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
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		
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.							
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		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
				1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)					N		60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0084

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From 12/01/2017
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Part I
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	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00		2.00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				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. Enter in column 4, the 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 through 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		
64.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		64.00

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

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				1.00				
Long Term Care Hospital PPS								
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00			
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00			
TEFRA Providers								
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00			
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00			
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00			
			V	XIX				
			1.00	2.00				
Title V and XIX Services								
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00		
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00		
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00		
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00		
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00		
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	95.00		
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N	96.00		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	97.00		
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	Y	98.00		
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	Y	98.01		
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	Y	98.02		
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N	98.03		
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N	98.04		
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	Y	98.05		
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	Y	98.06		
Rural Providers								
105.00	Does this hospital qualify as a CAH?			N		105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			N		106.00		
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			N		107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108.00		
			Physical	Occupational	Speech	Respiratory		
			1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			N	N	N	N	109.00
						1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N			110.00

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			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
			1.00	2.00	3.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	164,821	0	0	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		HB0776	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0084		Period: From 12/01/2017 To 11/30/2018		Worksheet S-2 Part I Date/Time Prepared: 4/29/2019 2:06 pm		
1.00		2.00		3.00						
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.										
141.00	Name: QUORUM HEALTH CORPORATION		Contractor's Name: WPS		Contractor's Number: 52280				141.00	
142.00	Street: 1573 MALLORY LANE		PO Box:						142.00	
143.00	City: BRENTWOOD		State: TN		Zip Code: 37027				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.				Y				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N				146.00	
								1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital			N	N	N	N			155.00
156.00	Subprovider - IPF			N	N	N	N			156.00
157.00	Subprovider - IRF			N	N	N	N			157.00
158.00	SUBPROVIDER									158.00
159.00	SNF			N	N	N	N			159.00
160.00	HOME HEALTH AGENCY			N	N	N	N			160.00
161.00	CMHC				N	N	N			161.00
								1.00		
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)								9.99	169.00
						Beginning	Ending			
						1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)						10/01/2017	09/30/2018	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: 14-0084		Period: From 12/01/2017 To 11/30/2018		Worksheet S-2 Part II Date/Time Prepared: 4/29/2019 2:06 pm	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					Y	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			Y	03/21/2019	Y	03/21/2019
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018Worksheet S-2
Part II
Date/Time Prepared:
4/29/2019 2:06 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.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		Y	12/31/2017	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MORAN	JOSEPH		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) 221-3613	JOSEPH_MORAN@QUORUMHEALTH.CO M		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0084	Period: From 12/01/2017 To 11/30/2018	Worksheet S-2 Part II Date/Time Prepared: 4/29/2019 2:06 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.	MANAGER, REIMBURSEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018Worksheet S-3
Part I
Date/Time Prepared:
4/29/2019 2:06 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	167	60,955	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		167	60,955	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	23	8,395	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		190	69,350	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		190				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018Worksheet S-3
Part I
Date/Time Prepared:
4/29/2019 2:06 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)	14,096	1,285	33,611			1.00
2.00	HMO and other (see instructions)	4,301	11,208				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	14,096	1,285	33,611			7.00
8.00	INTENSIVE CARE UNIT	2,082	154	4,995			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		1,452	3,353			13.00
14.00	Total (see instructions)	16,178	2,891	41,959	0.00	807.92	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	807.92	27.00
28.00	Observation Bed Days		0	4,994			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	133	205			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018Worksheet S-3
Part I
Date/Time Prepared:
4/29/2019 2:06 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	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	3,033	3,133	9,998	1.00
2.00 HMO and other (see instructions)			0	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	3,033	3,133	9,998	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018Worksheet S-3
Part II
Date/Time Prepared:
4/29/2019 2:06 pm

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	54,574,997	0	54,574,997	1,680,477.00	32.48
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		736,153	213,047	949,200	19,663.00	48.27
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		386,171	0	386,171	5,782.00	66.79
12.00	Contract labor: Top level management and other management and administrative services		690,971	0	690,971	5,623.00	122.88
13.00	Contract labor: Physician-Part A - Administrative		183,298	0	183,298	1,401.00	130.83
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		1,786,902	0	1,786,902	24,386.00	73.28
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		11,231,077	0	11,231,077		
18.00	Wage-related costs (other) (see instructions)		113,083	0	113,083		
19.00	Excluded areas		132,847	0	132,847		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	318,447	0	318,447	7,599.00	41.91
27.00	Administrative & General	5.00	5,104,833	-213,047	4,891,786	187,945.00	26.03

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018Worksheet S-3
Part II
Date/Time Prepared:
4/29/2019 2:06 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,069,483	0	1,069,483	36,787.00	29.07	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	4,005,948	0	4,005,948	95,513.00	41.94	38.00
39.00	Central Services and Supply	14.00	385,976	0	385,976	24,230.00	15.93	39.00
40.00	Pharmacy	15.00	1,715,244	0	1,715,244	42,932.00	39.95	40.00
41.00	Medical Records & Medical Records Library	16.00	1,009,632	0	1,009,632	38,728.00	26.07	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: 14-0084

Period:
From 12/01/2017
To 11/30/2018Worksheet S-3
Part III
Date/Time Prepared:
4/29/2019 2:06 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	54,574,997	0	54,574,997	1,680,477.00	32.48	1.00
2.00	Excluded area salaries (see instructions)	736,153	213,047	949,200	19,663.00	48.27	2.00
3.00	Subtotal salaries (line 1 minus line 2)	53,838,844	-213,047	53,625,797	1,660,814.00	32.29	3.00
4.00	Subtotal other wages & related costs (see inst.)	3,047,342	0	3,047,342	37,192.00	81.94	4.00
5.00	Subtotal wage-related costs (see inst.)	11,344,160	0	11,344,160	0.00	21.15	5.00
6.00	Total (sum of lines 3 thru 5)	68,230,346	-213,047	68,017,299	1,698,006.00	40.06	6.00
7.00	Total overhead cost (see instructions)	13,609,563	-213,047	13,396,516	433,734.00	30.89	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0084	Period: From 12/01/2017 To 11/30/2018	Worksheet S-3 Part IV Date/Time Prepared: 4/29/2019 2:06 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		989,936	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		5,451,108	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		45,549	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		42,560	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		-9,216	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		189,134	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		430,594	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		3,167,960	17.00
18.00	Medicare Taxes - Employers Portion Only		740,894	18.00
19.00	Unemployment Insurance		0	19.00
20.00	State or Federal Unemployment Taxes		202,323	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)		11,250,842	24.00
Part B - Other than Core Related Cost				
25.00	OTHER BENEFITS		113,083	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018Worksheet S-3
Part V
Date/Time Prepared:
4/29/2019 2:06 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	386,171	11,250,842	1.00
2.00	Hospital	386,171	11,250,842	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018

Worksheet S-10

Date/Time Prepared:
4/29/2019 2:06 pm

				4/29/2019 2:06 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)			0.097837	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			24,168,280	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			8,125,673	5.00
6.00	Medicaid charges			372,094,169	6.00
7.00	Medicaid cost (line 1 times line 6)			36,404,577	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)			4,110,624	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			3,958	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			387	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			387	12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			4,111,011	19.00
				Uninsured patients	Insured patients
				1.00	2.00
				Total (col. 1 + col. 2)	
				3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)		20,654,600	0	20,654,600
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)		2,020,784	0	2,020,784
22.00	Payments received from patients for amounts previously written off as charity care		238,177	0	238,177
23.00	Cost of charity care (line 21 minus line 22)		1,782,607	0	1,782,607
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			14,729,357	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			956,459	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			1,471,475	27.01
28.00	Non-Medicare bad debt expense (see instructions)			13,257,882	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			1,812,127	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			3,594,734	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			7,705,745	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018

Worksheet A

Date/Time Prepared:
4/29/2019 2:06 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		3,013,860	3,013,860	3,083,597	6,097,457	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,889,875	3,889,875	3,275,522	7,165,397	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	318,447	151,377	469,824	7,143,269	7,613,093	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,104,833	38,308,297	43,413,130	-11,085,172	32,327,958	5.00
7.00	00700	OPERATION OF PLANT	1,069,483	3,653,064	4,722,547	-2,454	4,720,093	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	607,201	607,201	0	607,201	8.00
9.00	00900	HOUSEKEEPING	0	2,324,668	2,324,668	-166	2,324,502	9.00
10.00	01000	DIETARY	0	3,246,376	3,246,376	-4,448	3,241,928	10.00
13.00	01300	NURSING ADMINISTRATION	4,005,948	676,623	4,682,571	-2,809	4,679,762	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	385,976	8,205,604	8,591,580	-7,387,294	1,204,286	14.00
15.00	01500	PHARMACY	1,715,244	5,178,784	6,894,028	-4,703,106	2,190,922	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,009,632	767,526	1,777,158	-8,337	1,768,821	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,761,075	4,028,212	15,789,287	150,999	15,940,286	30.00
31.00	03100	INTENSIVE CARE UNIT	3,613,214	969,697	4,582,911	-2,917	4,579,994	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	875,720	181,522	1,057,242	333,851	1,391,093	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,479,548	4,528,428	7,007,976	-957,167	6,050,809	50.00
51.00	05100	RECOVERY ROOM	1,407,592	130,192	1,537,784	-1,959	1,535,825	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,751,690	852,804	2,604,494	-511,517	2,092,977	52.00
53.00	05300	ANESTHESIOLOGY	40,046	1,119,098	1,159,144	-543	1,158,601	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,094,887	2,690,679	5,785,566	1,522,924	7,308,490	54.00
54.01	05401	ULTRASOUND	443,577	108,291	551,868	-551,868	0	54.01
56.00	05600	RADIOISOTOPE	232,505	357,085	589,590	-589,590	0	56.00
57.00	05700	CT SCAN	427,368	384,250	811,618	-811,618	0	57.00
58.00	05800	MRI	138,710	168,466	307,176	-307,176	0	58.00
60.00	06000	LABORATORY	3,504,726	3,956,267	7,460,993	-200,236	7,260,757	60.00
65.00	06500	RESPIRATORY THERAPY	1,150,156	735,899	1,886,055	-415,073	1,470,982	65.00
66.00	06600	PHYSICAL THERAPY	1,643,919	377,497	2,021,416	423,811	2,445,227	66.00
67.00	06700	OCCUPATIONAL THERAPY	194,984	14,263	209,247	-209,247	0	67.00
68.00	06800	SPEECH PATHOLOGY	218,773	17,409	236,182	-236,182	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,937,602	1,269,800	3,207,402	-167,604	3,039,798	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,966,592	2,966,592	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,415,097	4,415,097	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,521,303	4,521,303	73.00
74.00	07400	RENAL DIALYSIS	0	1,032,041	1,032,041	0	1,032,041	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03030	SLEEP LAB	0	0	0	0	0	76.01
76.02	03951	PSYCH SERVICES	12,058	69,782	81,840	-78	81,762	76.02
76.03	03952	WOUND CARE	83,893	13,153	97,046	-97,046	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	5,217,238	4,423,542	9,640,780	18,387	9,659,167	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	231,499	452,087	683,586	-207,553	476,033	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	54,070,343	97,903,719	151,974,062	-605,808	151,368,254	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	-29,295	-29,295	33,776	4,481	192.00
194.00	07950	CLINIC CORPORATION	0	0	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	0	34,701	34,701	0	34,701	194.01
194.02	07952	MARKETING	0	0	0	564,691	564,691	194.02
194.03	07953	VISTA MEDICAL CENTER WEST	0	0	0	7,341	7,341	194.03
194.04	07954	OTHER NON-REIMBURSABLE	25,035	2,299	27,334	0	27,334	194.04
194.05	07955	INDUSTRIAL MEDICINE	479,619	148,587	628,206	0	628,206	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	54,574,997	98,060,011	152,635,008	0	152,635,008	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018

Worksheet A

Date/Time Prepared:
4/29/2019 2:06 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	1,069,832	7,167,289	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-1,790,997	5,374,400	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-12,992	7,600,101	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-14,253,549	18,074,409	5.00
7.00	00700	OPERATION OF PLANT	-54,627	4,665,466	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	607,201	8.00
9.00	00900	HOUSEKEEPING	-224,720	2,099,782	9.00
10.00	01000	DIETARY	-3,501	3,238,427	10.00
13.00	01300	NURSING ADMINISTRATION	-681	4,679,081	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,204,286	14.00
15.00	01500	PHARMACY	0	2,190,922	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3,719	1,765,102	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,204,326	13,735,960	30.00
31.00	03100	INTENSIVE CARE UNIT	-144,676	4,435,318	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
43.00	04300	NURSERY	0	1,391,093	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-1,147,432	4,903,377	50.00
51.00	05100	RECOVERY ROOM	0	1,535,825	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,092,977	52.00
53.00	05300	ANESTHESIOLOGY	-849,025	309,576	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-2,184	7,306,306	54.00
54.01	05401	ULTRASOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	0	7,260,757	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,470,982	65.00
66.00	06600	PHYSICAL THERAPY	0	2,445,227	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	-185,588	2,854,210	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,966,592	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,415,097	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,521,303	73.00
74.00	07400	RENAL DIALYSIS	0	1,032,041	74.00
76.00	03020	CARDIAC REHAB	0	0	76.00
76.01	03030	SLEEP LAB	0	0	76.01
76.02	03951	PSYCH SERVICES	0	81,762	76.02
76.03	03952	WOUND CARE	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-3,073,985	6,585,182	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-275,112	200,921	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-23,157,282	128,210,972	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,481	192.00
194.00	07950	CLINIC CORPORATION	0	0	194.00
194.01	07951	SENIOR CIRCLE	0	34,701	194.01
194.02	07952	MARKETING	0	564,691	194.02
194.03	07953	VISTA MEDICAL CENTER WEST	0	7,341	194.03
194.04	07954	OTHER NON-REIMBURSABLE	0	27,334	194.04
194.05	07955	INDUSTRIAL MEDICINE	0	628,206	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	-23,157,282	129,477,726	200.00

RECLASSIFICATIONS

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018

Worksheet A-6

Date/Time Prepared:
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		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7,148,270		1.00
	0		0	7,148,270		
	B - RECLASS OXYGEN COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	65,656		1.00
2.00	OPERATING ROOM	50.00	0	2,336		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	0		0	67,992		
	C - RECLASS LEASE AND RENTAL EXP					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	696		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,264,098		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
	0		0	3,264,794		
	D - RECLASS OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	156,665		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,926,236		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	11,424		3.00
	0		0	3,094,325		
	E - RECLASS MARKETING DEPT.					
1.00	MARKETING	194.02	171,930	392,761		1.00
	TOTALS		171,930	392,761		
	F - RECLASS MED. SUPP. CHRGD TO PATIENTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,900,936		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	4,415,097		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	7,316,033		
	G - RECLASS DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,521,303		1.00
	TOTALS		0	4,521,303		
	H - RECLASS LABOR & DELIVERY					
1.00	ADULTS & PEDIATRICS	30.00	195,129	0		1.00
2.00	NURSERY	43.00	98,415	245,391		2.00
	TOTALS		293,544	245,391		
	I - RECLASS PT, OT, AND SP SERVICES					
1.00	PHYSICAL THERAPY	66.00	413,757	31,672		1.00
2.00		0.00	0	0		2.00
	TOTALS		413,757	31,672		
	J - RECLASS MISC SERVICES					
1.00	EMERGENCY	91.00	83,893	6,967		1.00
	TOTALS		83,893	6,967		
	K - RECLASS OTHER RADIOLOGY COSTS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	1,242,160	1,018,092		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00

RECLASSIFICATIONS

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018

Worksheet A-6

Date/Time Prepared:
4/29/2019 2:06 pm

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
4.00	_____	_____ 0.00	_____ 0	_____ 0	4.00
	TOTALS		1,242,160	1,018,092	
	L - ALLOCATION TO VISTA WEST				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	33,776	0	1.00
2.00	VISTA MEDICAL CENTER WEST	194.03	7,341	0	2.00
	TOTALS		41,117	0	
500.00	Grand Total: Increases		2,246,401	27,107,600	500.00

RECLASSIFICATIONS

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018

Worksheet A-6

Date/Time Prepared:
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	Decreases					4/29/2019 2:06 PM
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - RECLASS EMPLOYEE BENEFITS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	7,148,270	0	1.00
	0		0	7,148,270		
	B - RECLASS OXYGEN COSTS					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	4,062	0	1.00
2.00	ANESTHESIOLOGY	53.00	0	543	0	2.00
3.00	RESPIRATORY THERAPY	65.00	0	62,772	0	3.00
4.00	EMERGENCY	91.00	0	615	0	4.00
	0		0	67,992		
	C - RECLASS LEASE AND RENTAL EXP					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5,001	10	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	236,769	10	2.00
3.00	OPERATION OF PLANT	7.00	0	2,454	0	3.00
4.00	HOUSEKEEPING	9.00	0	166	0	4.00
5.00	DIETARY	10.00	0	4,448	0	5.00
6.00	NURSING ADMINISTRATION	13.00	0	2,809	0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	125,557	0	7.00
8.00	PHARMACY	15.00	0	181,803	0	8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	8,337	0	9.00
10.00	ADULTS & PEDIATRICS	30.00	0	12,514	0	10.00
11.00	INTENSIVE CARE UNIT	31.00	0	2,917	0	11.00
12.00	NURSERY	43.00	0	9,955	0	12.00
13.00	OPERATING ROOM	50.00	0	931,130	0	13.00
14.00	RECOVERY ROOM	51.00	0	1,959	0	14.00
15.00	DELIVERY ROOM & LABOR ROOM	52.00	0	4,198	0	15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	659,213	0	16.00
17.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,022	0	17.00
18.00	RADIOLOGY-DIAGNOSTIC	54.00	0	558	0	18.00
19.00	RADIOLOGY-DIAGNOSTIC	54.00	0	74,491	0	19.00
20.00	RADIOLOGY-DIAGNOSTIC	54.00	0	407	0	20.00
21.00	LABORATORY	60.00	0	200,236	0	21.00
22.00	RESPIRATORY THERAPY	65.00	0	352,301	0	22.00
23.00	PHYSICAL THERAPY	66.00	0	21,618	0	23.00
24.00	ELECTROCARDIOLOGY	69.00	0	137,619	0	24.00
25.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,637	0	25.00
26.00	PSYCH SERVICES	76.02	0	78	0	26.00
27.00	WOUND CARE	76.03	0	6,186	0	27.00
28.00	EMERGENCY	91.00	0	71,858	0	28.00
29.00	AMBULANCE SERVICES	95.00	0	207,553	0	29.00
	0		0	3,264,794		
	D - RECLASS OTHER CAPITAL COSTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,094,325	12	1.00
2.00		0.00	0	0	13	2.00
3.00		0.00	0	0	12	3.00
	0		0	3,094,325		
	E - RECLASS MARKETING DEPT.					
1.00	ADMINISTRATIVE & GENERAL	5.00	171,930	392,761	0	1.00
	TOTALS		171,930	392,761		
	F - RECLASS MED. SUPP. CHRGD TO PATIENTS					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	7,257,675	0	1.00
2.00	OPERATING ROOM	50.00	0	28,373	0	2.00
3.00	ELECTROCARDIOLOGY	69.00	0	29,985	0	3.00
	TOTALS		0	7,316,033		
	G - RECLASS DRUGS CHARGED TO PATIENTS					
1.00	PHARMACY	15.00	0	4,521,303	0	1.00
	TOTALS		0	4,521,303		
	H - RECLASS LABOR & DELIVERY					
1.00	ADULTS & PEDIATRICS	30.00	0	31,616	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	293,544	213,775	0	2.00
	TOTALS		293,544	245,391		
	I - RECLASS PT, OT, AND SP SERVICES					
1.00	OCCUPATIONAL THERAPY	67.00	194,984	14,263	0	1.00
2.00	SPEECH PATHOLOGY	68.00	218,773	17,409	0	2.00
	TOTALS		413,757	31,672		
	J - RECLASS MISC SERVICES					
1.00	WOUND CARE	76.03	83,893	6,967	0	1.00
	TOTALS		83,893	6,967		
	K - RECLASS OTHER RADIOLOGY COSTS					
1.00	ULTRASOUND	54.01	443,577	108,291	0	1.00
2.00	RADIOISOTOPE	56.00	232,505	357,085	0	2.00
3.00	CT SCAN	57.00	427,368	384,250	0	3.00
4.00	MRI	58.00	138,710	168,466	0	4.00
	TOTALS		1,242,160	1,018,092		

RECLASSIFICATIONS

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018

Worksheet A-6

Date/Time Prepared:
4/29/2019 2:06 pm

	Decreases						4/23/2019 1:00 pm
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	L - ALLOCATION TO VISTA WEST						
1.00	ADMINISTRATIVE & GENERAL	5.00	41,117	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		41,117	0			
500.00	Grand Total: Decreases		2,246,401	27,107,600			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018Worksheet A-7
Part I
Date/Time Prepared:
4/29/2019 2:06 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	67,659	0	0	0	0	1.00	
2.00	Land Improvements	464,176	0	0	0	0	2.00	
3.00	Buildings and Fixtures	96,570,367	25,264	0	25,264	0	3.00	
4.00	Building Improvements	80,934,815	88,599	0	88,599	3,188	4.00	
5.00	Fixed Equipment	5,027,971	89,386	0	89,386	0	5.00	
6.00	Movable Equipment	34,245,756	325,418	0	325,418	2,770	6.00	
7.00	HIT designated Assets	18,461,398	21,770	0	21,770	0	7.00	
8.00	Subtotal (sum of lines 1-7)	235,772,142	550,437	0	550,437	5,958	8.00	
9.00	Reconciling Items	0	-776,996	0	-776,996	0	9.00	
10.00	Total (line 8 minus line 9)	235,772,142	1,327,433	0	1,327,433	5,958	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	67,659	0				1.00	
2.00	Land Improvements	464,176	0				2.00	
3.00	Buildings and Fixtures	96,595,631	0				3.00	
4.00	Building Improvements	81,020,226	0				4.00	
5.00	Fixed Equipment	5,117,357	0				5.00	
6.00	Movable Equipment	34,568,404	0				6.00	
7.00	HIT designated Assets	18,483,168	0				7.00	
8.00	Subtotal (sum of lines 1-7)	236,316,621	0				8.00	
9.00	Reconciling Items	-776,996	0				9.00	
10.00	Total (line 8 minus line 9)	237,093,617	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018Worksheet A-7
Part II
Date/Time Prepared:
4/29/2019 2:06 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	3,013,860	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,889,875	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	6,903,735	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	3,013,860				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,889,875				2.00
3.00	Total (sum of lines 1-2)	0	6,903,735				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018Worksheet A-7
Part III
Date/Time Prepared:
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Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	178,147,692	0	178,147,692	0.753347	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	58,327,135	0	58,327,135	0.246653	0	2.00
3.00	Total (sum of lines 1-2)	236,474,827	0	236,474,827	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	4,083,692	696	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,098,878	3,264,098	2.00
3.00	Total (sum of lines 1-2)	0	0	0	6,182,570	3,264,794	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	156,665	2,926,236	0	7,167,289	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	11,424	0	0	5,374,400	2.00
3.00	Total (sum of lines 1-2)	0	168,089	2,926,236	0	12,541,689	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018

Worksheet A-8

Date/Time Prepared:
4/29/2019 2:06 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)			0	0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)			0	0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)			0	0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)			0	0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A		0ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A		0CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)			0	0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-7,610,216			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B		0RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-2,425,922			0	12.00
13.00	Laundry and linen service			0	0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-3,501	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others			0	0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B		0MEDICAL RECORDS & LIBRARY	16.00	0	16.00
17.00	Sale of drugs to other than patients	B		0DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-3,719	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)			0	0.00	0	19.00
20.00	Vending machines	B	-4,768	ADMINISTRATIVE & GENERAL	5.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)			0	0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0	0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL 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	883,782	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-1,800,680	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		0OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0	0.00	0	32.00
33.00	INSERVICE EDUCATION REVENUE	B	-681	NURSING ADMINISTRATION	13.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018

Worksheet A-8

Date/Time Prepared:
4/29/2019 2:06 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
34.00	FITNESS REVENUE	B	-39,907	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	CARELINE REVENUE	B	-25,164	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	RENTAL INCOME	B	-29,242	CAP REL COSTS-BLDG & FIXT	1.00	9	36.00
37.00	OTHER MISC REVENUE	B	-221,114	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	DEPRECIATION - A&G	A	-206,518	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	39.00
40.00	NON-ALLOWABLE PHONE / TV	A	-248,875	ADMINISTRATIVE & GENERAL	5.00	0	40.00
40.01	NON-ALLOWABLE TV	A	-13,755	ADMINISTRATIVE & GENERAL	5.00	0	40.01
40.02	NON-ALLOWABLE PHONE & TV DEPR	A	-21,697	CAP REL COSTS-MVBLE EQUIP	2.00	9	40.02
40.03	NON-ALLOWABLE PHONE / TV BENEFITS	A	-12,992	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.03
40.04	NON-RESTRICTED DONATION	A	0	ADMINISTRATIVE & GENERAL	5.00	0	40.04
40.05	GRANT REVENUE	B	1,200	ADMINISTRATIVE & GENERAL	5.00	0	40.05
41.00	PHYSICIAN RECRUITING	A	-208,050	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	STATE OPERATING TAX	A	-10,279,042	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	CLUB DUES AND LOBBYING	A	-86,680	ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00	LEGAL FEES	A	-251,564	ADMINISTRATIVE & GENERAL	5.00	0	44.00
44.01	ALLOCATED RECOVERY ROOM	A	0	RECOVERY ROOM	51.00	0	44.01
44.02	ALLOCATED ANESTHESIA	A	0	ANESTHESIOLOGY	53.00	0	44.02
44.03	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.03
44.04	AMBULANCE TRAINING	B	-272,112	AMBULANCE SERVICES	95.00	0	44.04
45.01	ALLOCATED SECURITY / PLANT OPS	A	-54,627	OPERATION OF PLANT	7.00	0	45.01
45.02	ALLOCATED HOUSEKEEPING	A	-224,720	HOUSEKEEPING	9.00	0	45.02
45.06	ALLOCATED EKG	A	0	ELECTROCARDIOLOGY	69.00	0	45.06
45.07	ALLOCATED BUSINESS OFFICE FROM WEST	A	3,282	ADMINISTRATIVE & GENERAL	5.00	0	45.07
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-23,157,282				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018

Worksheet A-8-1

Date/Time Prepared:
4/29/2019 2:06 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	0.00			0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	2,972,338	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	POOLED ALLOCATION OF NON-CAP	1,042,296	0	3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	215,292	0	4.00
4.01	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	31,380	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL FUNCTIONAL ALLOC	1,857,024	0	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE COSTS	229,498	2,829,074	4.03
4.04	0.00			0	0	4.04
4.05	0.00			0	0	4.05
4.06	0.00			0	0	4.06
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			3,375,490	5,801,412	5.00

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

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

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

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

6.00	B		0.00	QUORUM HEALTH C	100.00	6.00
7.00			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: 14-0084

Period:
From 12/01/2017
To 11/30/2018

Worksheet A-8-1

Date/Time Prepared:
4/29/2019 2:06 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	0	0		1.00
2.00	-2,972,338	0		2.00
3.00	1,042,296	0		3.00
4.00	215,292	9		4.00
4.01	31,380	9		4.01
4.02	1,857,024	0		4.02
4.03	-2,599,576	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
5.00	-2,425,922			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: 14-0084

Period:
From 12/01/2017
To 11/30/2018

Worksheet A-8-2

Date/Time Prepared:
4/29/2019 2:06 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	0.00		0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	2,204,326	2,204,326	0	0	0	3.00
4.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	144,676	144,676	0	0	0	4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	1,147,432	1,147,432	0	0	0	5.00
6.00	53.00	AGGREGATE-ANESTHESIOLOGY	849,025	849,025	0	0	0	6.00
7.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	2,184	2,184	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	69.00	AGGREGATE-ELECTROCARDIOLOGY	185,588	185,588	0	0	0	10.00
14.00	91.00	AGGREGATE-EMERGENCY	3,073,985	3,073,985	0	0	0	14.00
15.00	95.00	AGGREGATE-AMBULANCE SERVICES	3,000	3,000	0	0	0	15.00
200.00			7,610,216	7,610,216	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	0.00		0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	0	0	4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	5.00
6.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	0	0	6.00
7.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	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	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	0	0	10.00
14.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	14.00
15.00	95.00	AGGREGATE-AMBULANCE SERVICES	0	0	0	0	0	15.00
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	0.00		0	0	0	0		1.00
2.00	0.00		0	0	0	0		2.00
3.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	2,204,326		3.00
4.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	144,676		4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	1,147,432		5.00
6.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	849,025		6.00
7.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	2,184		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	185,588		10.00
14.00	91.00	AGGREGATE-EMERGENCY	0	0	0	3,073,985		14.00
15.00	95.00	AGGREGATE-AMBULANCE SERVICES	0	0	0	3,000		15.00
200.00			0	0	0	7,610,216		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018Worksheet B
Part I
Date/Time Prepared:
4/29/2019 2:06 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	7,167,289	7,167,289			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	5,374,400		5,374,400		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,600,101	110,184	80,046	7,790,331	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,074,409	601,936	604,823	702,377	5.00
7.00	00700	OPERATION OF PLANT	4,665,466	2,018,527	1,466,414	153,560	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	607,201	123,497	89,718	0	8.00
9.00	00900	HOUSEKEEPING	2,099,782	67,537	49,064	0	9.00
10.00	01000	DIETARY	3,238,427	218,617	158,820	0	10.00
13.00	01300	NURSING ADMINISTRATION	4,679,081	37,071	26,931	575,186	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,204,286	168,115	122,132	55,420	14.00
15.00	01500	PHARMACY	2,190,922	49,443	35,919	246,280	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,765,102	78,541	57,058	144,966	16.00
17.00	01700	SOCIAL SERVICE	0	6,443	4,681	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	13,735,960	1,132,010	822,379	1,716,721	30.00
31.00	03100	INTENSIVE CARE UNIT	4,435,318	202,465	147,086	518,796	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
43.00	04300	NURSERY	1,391,093	36,998	26,878	139,869	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,903,377	396,721	288,208	356,021	50.00
51.00	05100	RECOVERY ROOM	1,535,825	48,575	35,289	202,106	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,092,977	125,689	91,310	209,365	52.00
53.00	05300	ANESTHESIOLOGY	309,576	13,254	9,629	5,750	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,306,306	384,084	279,028	622,726	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	7,260,757	158,671	115,271	503,219	60.00
65.00	06500	RESPIRATORY THERAPY	1,470,982	53,209	38,655	165,143	65.00
66.00	06600	PHYSICAL THERAPY	2,445,227	158,038	114,811	295,447	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,854,210	81,424	59,153	278,207	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,966,592	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,415,097	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,521,303	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,032,041	0	0	0	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	76.00
76.01	03030	SLEEP LAB	0	0	0	0	76.01
76.02	03951	PSYCH SERVICES	81,762	0	0	1,731	76.02
76.03	03952	WOUND CARE	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	6,585,182	318,518	231,396	761,152	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	200,921	0	0	33,239	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	128,210,972	6,589,567	4,954,699	7,687,281	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,481	0	0	4,850	192.00
194.00	07950	CLINIC CORPORATION	0	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	34,701	2,986	2,169	0	194.01
194.02	07952	MARKETING	564,691	0	0	24,686	194.02
194.03	07953	VISTA MEDICAL CENTER WEST	7,341	0	0	1,054	194.03
194.04	07954	OTHER NON-REIMBURSABLE	27,334	574,736	417,532	3,595	194.04
194.05	07955	INDUSTRIAL MEDICINE	628,206	0	0	68,865	194.05
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	129,477,726	7,167,289	5,374,400	7,790,331	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018Worksheet B
Part I
Date/Time Prepared:
4/29/2019 2:06 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	19,983,545					5.00
7.00	00700	OPERATION OF PLANT	1,515,540	9,819,507				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	149,732	273,333	1,243,481			8.00
9.00	00900	HOUSEKEEPING	404,508	149,478	0	2,770,369		9.00
10.00	01000	DIETARY	659,924	483,860	0	142,653	4,902,301	10.00
13.00	01300	NURSING ADMINISTRATION	970,627	82,049	0	24,190	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	282,879	372,084	34,228	109,699	0	14.00
15.00	01500	PHARMACY	460,388	109,431	0	32,263	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	373,351	173,833	0	51,250	0	16.00
17.00	01700	SOCIAL SERVICE	2,030	14,261	0	4,204	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,176,910	2,505,448	506,644	738,668	4,394,250	30.00
31.00	03100	INTENSIVE CARE UNIT	967,961	448,110	105,082	132,113	340,740	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	291,071	81,886	13,037	24,142	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,084,887	878,052	113,539	258,870	0	50.00
51.00	05100	RECOVERY ROOM	332,492	107,510	49,624	31,696	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	459,800	278,184	111,308	82,015	0	52.00
53.00	05300	ANESTHESIOLOGY	61,726	29,336	0	8,649	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,568,135	850,083	92,873	250,625	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,466,984	351,182	0	103,537	0	60.00
65.00	06500	RESPIRATORY THERAPY	315,372	117,766	3,228	34,720	0	65.00
66.00	06600	PHYSICAL THERAPY	549,992	349,782	279	103,124	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	597,348	180,214	22,804	53,131	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	541,427	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	805,791	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	825,174	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	188,356	0	0	0	0	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03030	SLEEP LAB	0	0	0	0	0	76.01
76.02	03951	PSYCH SERVICES	15,238	0	0	0	0	76.02
76.03	03952	WOUND CARE	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,441,128	704,968	190,835	207,841	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	42,736	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,551,507	8,540,850	1,243,481	2,393,390	4,734,990	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,703	0	0	0	0	192.00
194.00	07950	CLINIC CORPORATION	0	0	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	7,274	6,609	0	1,949	0	194.01
194.02	07952	MARKETING	107,566	0	0	0	0	194.02
194.03	07953	VISTA MEDICAL CENTER WEST	1,532	0	0	0	167,311	194.03
194.04	07954	OTHER NON-REIMBURSABLE	186,742	1,272,048	0	375,030	0	194.04
194.05	07955	INDUSTRIAL MEDICINE	127,221	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	19,983,545	9,819,507	1,243,481	2,770,369	4,902,301	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018Worksheet B
Part I
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Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION	6,395,135					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,348,843				14.00
15.00	01500	PHARMACY	0	24,317	3,148,963			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,395	0	2,645,496		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	31,619	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,814,168	137,452	0	259,016	25,359	30.00
31.00	03100	INTENSIVE CARE UNIT	850,453	77,049	0	54,944	3,746	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	229,285	17,125	0	13,728	2,514	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	583,619	281,673	0	461,422	0	50.00
51.00	05100	RECOVERY ROOM	331,309	3,760	0	43,116	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	343,208	41,922	0	23,485	0	52.00
53.00	05300	ANESTHESIOLOGY	9,426	43,825	0	13,864	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	66,072	0	512,439	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	180,007	0	261,700	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	35,372	0	52,398	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,783	0	51,636	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	81,480	0	143,161	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	502,934	0	22,033	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	721,596	0	76,085	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,148,963	303,847	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	13,834	0	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03030	SLEEP LAB	0	0	0	0	0	76.01
76.02	03951	PSYCH SERVICES	0	0	0	1,025	0	76.02
76.03	03952	WOUND CARE	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,233,667	120,043	0	337,763	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	8,442	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,395,135	2,346,247	3,148,963	2,645,496	31,619	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CLINIC CORPORATION	0	0	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	0	2,446	0	0	0	194.01
194.02	07952	MARKETING	0	150	0	0	0	194.02
194.03	07953	VISTA MEDICAL CENTER WEST	0	0	0	0	0	194.03
194.04	07954	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.04
194.05	07955	INDUSTRIAL MEDICINE	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,395,135	2,348,843	3,148,963	2,645,496	31,619	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0084

Period:
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To 11/30/2018Worksheet B
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	31,964,985	0	31,964,985	30.00
31.00	03100	INTENSIVE CARE UNIT	8,283,863	0	8,283,863	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	41.00
43.00	04300	NURSERY	2,267,626	0	2,267,626	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,606,389	0	9,606,389	50.00
51.00	05100	RECOVERY ROOM	2,721,302	0	2,721,302	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,859,263	0	3,859,263	52.00
53.00	05300	ANESTHESIOLOGY	505,035	0	505,035	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,932,371	0	11,932,371	54.00
54.01	05401	ULTRASOUND	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MRI	0	0	0	58.00
60.00	06000	LABORATORY	10,401,328	0	10,401,328	60.00
65.00	06500	RESPIRATORY THERAPY	2,286,845	0	2,286,845	65.00
66.00	06600	PHYSICAL THERAPY	4,070,119	0	4,070,119	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,351,132	0	4,351,132	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,032,986	0	4,032,986	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,018,569	0	6,018,569	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,799,287	0	8,799,287	73.00
74.00	07400	RENAL DIALYSIS	1,234,231	0	1,234,231	74.00
76.00	03020	CARDIAC REHAB	0	0	0	76.00
76.01	03030	SLEEP LAB	0	0	0	76.01
76.02	03951	PSYCH SERVICES	99,756	0	99,756	76.02
76.03	03952	WOUND CARE	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	12,132,493	0	12,132,493	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	285,338	0	285,338	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	124,852,918	0	124,852,918	118.00
NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,034	0	11,034	192.00
194.00	07950	CLINIC CORPORATION	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	58,134	0	58,134	194.01
194.02	07952	MARKETING	697,093	0	697,093	194.02
194.03	07953	VISTA MEDICAL CENTER WEST	177,238	0	177,238	194.03
194.04	07954	OTHER NON-REIMBURSABLE	2,857,017	0	2,857,017	194.04
194.05	07955	INDUSTRIAL MEDICINE	824,292	0	824,292	194.05
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	129,477,726	0	129,477,726	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018Worksheet B
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			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	110,184	80,046	190,230	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	601,936	604,823	1,206,759	5.00
7.00	00700	OPERATION OF PLANT	0	2,018,527	1,466,414	3,484,941	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	123,497	89,718	213,215	8.00
9.00	00900	HOUSEKEEPING	0	67,537	49,064	116,601	9.00
10.00	01000	DIETARY	0	218,617	158,820	377,437	10.00
13.00	01300	NURSING ADMINISTRATION	0	37,071	26,931	64,002	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	168,115	122,132	290,247	14.00
15.00	01500	PHARMACY	0	49,443	35,919	85,362	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	78,541	57,058	135,599	16.00
17.00	01700	SOCIAL SERVICE	0	6,443	4,681	11,124	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	1,132,010	822,379	1,954,389	30.00
31.00	03100	INTENSIVE CARE UNIT	0	202,465	147,086	349,551	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
43.00	04300	NURSERY	0	36,998	26,878	63,876	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	396,721	288,208	684,929	50.00
51.00	05100	RECOVERY ROOM	0	48,575	35,289	83,864	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	125,689	91,310	216,999	52.00
53.00	05300	ANESTHESIOLOGY	0	13,254	9,629	22,883	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	384,084	279,028	663,112	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	158,671	115,271	273,942	60.00
65.00	06500	RESPIRATORY THERAPY	0	53,209	38,655	91,864	65.00
66.00	06600	PHYSICAL THERAPY	0	158,038	114,811	272,849	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	81,424	59,153	140,577	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	76.00
76.01	03030	SLEEP LAB	0	0	0	0	76.01
76.02	03951	PSYCH SERVICES	0	0	0	0	76.02
76.03	03952	WOUND CARE	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	318,518	231,396	549,914	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	812	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	6,589,567	4,954,699	11,544,266	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	118	192.00
194.00	07950	CLINIC CORPORATION	0	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	0	2,986	2,169	5,155	194.01
194.02	07952	MARKETING	0	0	0	603	194.02
194.03	07953	VISTA MEDICAL CENTER WEST	0	0	0	26	194.03
194.04	07954	OTHER NON-REIMBURSABLE	0	574,736	417,532	992,268	194.04
194.05	07955	INDUSTRIAL MEDICINE	0	0	0	1,682	194.05
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	7,167,289	5,374,400	12,541,689	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,223,910				5.00
7.00	00700	OPERATION OF PLANT	92,822	3,581,513			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,171	99,694	322,080		8.00
9.00	00900	HOUSEKEEPING	24,775	54,520	0	195,896	9.00
10.00	01000	DIETARY	40,418	176,480	0	10,087	604,422 10.00
13.00	01300	NURSING ADMINISTRATION	59,448	29,926	0	1,710	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	17,325	135,712	8,865	7,757	0 14.00
15.00	01500	PHARMACY	28,197	39,913	0	2,281	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	22,866	63,403	0	3,624	0 16.00
17.00	01700	SOCIAL SERVICE	124	5,201	0	297	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	194,561	913,824	131,230	52,233	541,783 30.00
31.00	03100	INTENSIVE CARE UNIT	59,284	163,441	27,218	9,342	42,011 31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0 40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0 41.00
43.00	04300	NURSERY	17,827	29,867	3,377	1,707	0 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	66,446	320,256	29,408	18,305	0 50.00
51.00	05100	RECOVERY ROOM	20,364	39,213	12,853	2,241	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	28,161	101,463	28,830	5,799	0 52.00
53.00	05300	ANESTHESIOLOGY	3,781	10,700	0	612	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	96,043	310,055	24,056	17,722	0 54.00
54.01	05401	ULTRASOUND	0	0	0	0	0 54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0 56.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MRI	0	0	0	0	0 58.00
60.00	06000	LABORATORY	89,848	128,088	0	7,321	0 60.00
65.00	06500	RESPIRATORY THERAPY	19,315	42,953	836	2,455	0 65.00
66.00	06600	PHYSICAL THERAPY	33,685	127,577	72	7,292	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	36,586	65,730	5,906	3,757	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	33,161	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	49,352	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	50,539	0	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	11,536	0	0	0	0 74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0 76.00
76.01	03030	SLEEP LAB	0	0	0	0	0 76.01
76.02	03951	PSYCH SERVICES	933	0	0	0	0 76.02
76.03	03952	WOUND CARE	0	0	0	0	0 76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	88,264	257,126	49,429	14,697	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	2,617	0	0	0	0 95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0	0	0 116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,197,449	3,115,142	322,080	169,239	583,794 118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	104	0	0	0	0 192.00
194.00	07950	CLINIC CORPORATION	0	0	0	0	0 194.00
194.01	07951	SENIOR CIRCLE	446	2,411	0	138	0 194.01
194.02	07952	MARKETING	6,588	0	0	0	0 194.02
194.03	07953	VISTA MEDICAL CENTER WEST	94	0	0	0	20,628 194.03
194.04	07954	OTHER NON-REIMBURSABLE	11,437	463,960	0	26,519	0 194.04
194.05	07955	INDUSTRIAL MEDICINE	7,792	0	0	0	0 194.05
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	1,223,910	3,581,513	322,080	195,896	604,422 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION	169,131					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	461,259				14.00
15.00	01500	PHARMACY	0	4,775	166,542			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	274	0	229,306		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	16,746	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	74,425	26,993	0	22,491	13,430	30.00
31.00	03100	INTENSIVE CARE UNIT	22,492	15,131	0	4,771	1,984	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	6,064	3,363	0	1,192	1,332	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	15,435	55,314	0	40,066	0	50.00
51.00	05100	RECOVERY ROOM	8,762	738	0	3,744	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,077	8,232	0	2,039	0	52.00
53.00	05300	ANESTHESIOLOGY	249	8,606	0	1,204	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,975	0	44,089	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	35,349	0	22,724	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	6,946	0	4,550	0	65.00
66.00	06600	PHYSICAL THERAPY	0	350	0	4,484	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	16,001	0	12,431	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	98,765	0	1,913	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	141,706	0	6,607	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	166,542	26,383	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,201	0	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03030	SLEEP LAB	0	0	0	0	0	76.01
76.02	03951	PSYCH SERVICES	0	0	0	89	0	76.02
76.03	03952	WOUND CARE	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	32,627	23,574	0	29,328	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	1,658	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	169,131	460,750	166,542	229,306	16,746	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CLINIC CORPORATION	0	0	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	0	480	0	0	0	194.01
194.02	07952	MARKETING	0	29	0	0	0	194.02
194.03	07953	VISTA MEDICAL CENTER WEST	0	0	0	0	0	194.03
194.04	07954	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.04
194.05	07955	INDUSTRIAL MEDICINE	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	169,131	461,259	166,542	229,306	16,746	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018Worksheet B
Part II
Date/Time Prepared:
4/29/2019 2:06 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,967,283	0	3,967,283	30.00
31.00	03100	INTENSIVE CARE UNIT	707,893	0	707,893	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	41.00
43.00	04300	NURSERY	132,020	0	132,020	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,238,852	0	1,238,852	50.00
51.00	05100	RECOVERY ROOM	176,714	0	176,714	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	405,712	0	405,712	52.00
53.00	05300	ANESTHESIOLOGY	48,175	0	48,175	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,183,258	0	1,183,258	54.00
54.01	05401	ULTRASOUND	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MRI	0	0	0	58.00
60.00	06000	LABORATORY	569,560	0	569,560	60.00
65.00	06500	RESPIRATORY THERAPY	172,951	0	172,951	65.00
66.00	06600	PHYSICAL THERAPY	453,523	0	453,523	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	287,781	0	287,781	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	133,839	0	133,839	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	197,665	0	197,665	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	243,464	0	243,464	73.00
74.00	07400	RENAL DIALYSIS	12,737	0	12,737	74.00
76.00	03020	CARDIAC REHAB	0	0	0	76.00
76.01	03030	SLEEP LAB	0	0	0	76.01
76.02	03951	PSYCH SERVICES	1,064	0	1,064	76.02
76.03	03952	WOUND CARE	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	1,063,545	0	1,063,545	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,087	0	5,087	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,001,123	0	11,001,123	118.00
NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	222	0	222	192.00
194.00	07950	CLINIC CORPORATION	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	8,630	0	8,630	194.01
194.02	07952	MARKETING	7,220	0	7,220	194.02
194.03	07953	VISTA MEDICAL CENTER WEST	20,748	0	20,748	194.03
194.04	07954	OTHER NON-REIMBURSABLE	1,494,272	0	1,494,272	194.04
194.05	07955	INDUSTRIAL MEDICINE	9,474	0	9,474	194.05
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	12,541,689	0	12,541,689	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018

Worksheet B-1

Date/Time Prepared:
4/29/2019 2:06 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	487,213				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		502,889			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,490	7,490	54,256,550		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	40,918	56,594	4,891,786	-19,983,545	5.00
7.00	00700	OPERATION OF PLANT	137,214	137,214	1,069,483	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,395	8,395	0	0	8.00
9.00	00900	HOUSEKEEPING	4,591	4,591	0	0	9.00
10.00	01000	DIETARY	14,861	14,861	0	0	10.00
13.00	01300	NURSING ADMINISTRATION	2,520	2,520	4,005,948	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,428	11,428	385,976	0	14.00
15.00	01500	PHARMACY	3,361	3,361	1,715,244	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,339	5,339	1,009,632	0	16.00
17.00	01700	SOCIAL SERVICE	438	438	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	76,951	76,951	11,956,204	0	30.00
31.00	03100	INTENSIVE CARE UNIT	13,763	13,763	3,613,214	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
43.00	04300	NURSERY	2,515	2,515	974,135	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	26,968	26,968	2,479,548	0	50.00
51.00	05100	RECOVERY ROOM	3,302	3,302	1,407,592	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,544	8,544	1,458,146	0	52.00
53.00	05300	ANESTHESIOLOGY	901	901	40,046	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,109	26,109	4,337,047	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	10,786	10,786	3,504,726	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,617	3,617	1,150,156	0	65.00
66.00	06600	PHYSICAL THERAPY	10,743	10,743	2,057,676	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,535	5,535	1,937,602	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	76.00
76.01	03030	SLEEP LAB	0	0	0	0	76.01
76.02	03951	PSYCH SERVICES	0	0	12,058	0	76.02
76.03	03952	WOUND CARE	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	21,652	21,652	5,301,131	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				7,896,248	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	231,499	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	447,941	463,617	53,538,849	-19,983,545	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	33,776	0	192.00
194.00	07950	CLINIC CORPORATION	0	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	203	203	0	0	194.01
194.02	07952	MARKETING	0	0	171,930	0	194.02
194.03	07953	VISTA MEDICAL CENTER WEST	0	0	7,341	0	194.03
194.04	07954	OTHER NON-REIMBURSABLE	39,069	39,069	25,035	0	194.04
194.05	07955	INDUSTRIAL MEDICINE	0	0	479,619	0	194.05
200.00		Cross Foot Adjustments				697,071	200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	7,167,289	5,374,400	7,790,331	19,983,545	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.710792	10.687050	0.143583	0.182508	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018

Worksheet B-1

Date/Time Prepared:
4/29/2019 2:06 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
204.00		Cost to be allocated (per Wkst. B, Part II)			190,230		1,223,910	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.003506		0.011178	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018

Worksheet B-1

Date/Time Prepared:
4/29/2019 2:06 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	301,591					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,395	980,827				8.00
9.00	00900	HOUSEKEEPING	4,591	0	288,605			9.00
10.00	01000	DIETARY	14,861	0	14,861	120,982		10.00
13.00	01300	NURSING ADMINISTRATION	2,520	0	2,520	0	27,170,213	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,428	26,998	11,428	0	0	14.00
15.00	01500	PHARMACY	3,361	0	3,361	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,339	0	5,339	0	0	16.00
17.00	01700	SOCIAL SERVICE	438	0	438	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	76,951	399,629	76,951	108,444	11,956,204	30.00
31.00	03100	INTENSIVE CARE UNIT	13,763	82,886	13,763	8,409	3,613,214	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	2,515	10,283	2,515	0	974,135	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	26,968	89,557	26,968	0	2,479,548	50.00
51.00	05100	RECOVERY ROOM	3,302	39,142	3,302	0	1,407,592	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,544	87,797	8,544	0	1,458,147	52.00
53.00	05300	ANESTHESIOLOGY	901	0	901	0	40,046	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,109	73,256	26,109	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	10,786	0	10,786	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,617	2,546	3,617	0	0	65.00
66.00	06600	PHYSICAL THERAPY	10,743	220	10,743	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,535	17,987	5,535	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03030	SLEEP LAB	0	0	0	0	0	76.01
76.02	03951	PSYCH SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	21,652	150,526	21,652	0	5,241,327	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	262,319	980,827	249,333	116,853	27,170,213	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CLINIC CORPORATION	0	0	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	203	0	203	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	VISTA MEDICAL CENTER WEST	0	0	0	4,129	0	194.03
194.04	07954	OTHER NON-REIMBURSABLE	39,069	0	39,069	0	0	194.04
194.05	07955	INDUSTRIAL MEDICINE	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	9,819,507	1,243,481	2,770,369	4,902,301	6,395,135	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	32.559019	1.267788	9.599172	40.520912	0.235373	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	3,581,513	322,080	195,896	604,422	169,131	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018

Worksheet B-1

Date/Time Prepared:
4/29/2019 2:06 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	
205.00	Unit cost multiplier (Wkst. B, Part II)	11.875397	0.328376	0.678769	4.995966	0.006225	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018

Worksheet B-1

Date/Time Prepared:
4/29/2019 2:06 pm

Cost Center Description			CENTRAL SERVICES & SUPPLY (TOTAL SUPP LIE)	PHARMACY (COSTED REQ UIS)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	SOCIAL SERVICE (PT. DAYS & OP OB)	
			14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,300,800				14.00
15.00	01500	PHARMACY	137,700	4,521,303			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,900	0	1,276,128,728		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	42,164	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	778,353	0	124,947,253	33,816	30.00
31.00	03100	INTENSIVE CARE UNIT	436,305	0	26,504,619	4,995	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
43.00	04300	NURSERY	96,976	0	6,622,361	3,353	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,595,034	0	222,586,414	0	50.00
51.00	05100	RECOVERY ROOM	21,290	0	20,798,611	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	237,391	0	11,328,830	0	52.00
53.00	05300	ANESTHESIOLOGY	248,169	0	6,687,828	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	374,145	0	247,157,532	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	1,019,329	0	126,242,255	0	60.00
65.00	06500	RESPIRATORY THERAPY	200,304	0	25,276,482	0	65.00
66.00	06600	PHYSICAL THERAPY	10,099	0	24,908,917	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	461,400	0	69,059,916	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,847,965	0	10,628,700	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,086,162	0	36,702,981	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,521,303	146,573,773	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	6,673,257	0	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	76.00
76.01	03030	SLEEP LAB	0	0	0	0	76.01
76.02	03951	PSYCH SERVICES	0	0	494,478	0	76.02
76.03	03952	WOUND CARE	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	679,769	0	162,934,521	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	47,807	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,286,098	4,521,303	1,276,128,728	42,164	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	CLINIC CORPORATION	0	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	13,852	0	0	0	194.01
194.02	07952	MARKETING	850	0	0	0	194.02
194.03	07953	VISTA MEDICAL CENTER WEST	0	0	0	0	194.03
194.04	07954	OTHER NON-REIMBURSABLE	0	0	0	0	194.04
194.05	07955	INDUSTRIAL MEDICINE	0	0	0	0	194.05
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)	2,348,843	3,148,963	2,645,496	31,619	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.176594	0.696472	0.002073	0.749905	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	461,259	166,542	229,306	16,746	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018

Worksheet B-1

Date/Time Prepared:
4/29/2019 2:06 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (TOTAL SUPP LIE)	PHARMACY (COSTED REQ UIS)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	SOCIAL SERVICE (PT. DAYS & OP OB)		
		14.00	15.00	16.00	17.00		
205.00	Unit cost multiplier (Wkst. B, Part II)	0.034679	0.036835	0.000180	0.397163		205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018Worksheet C
Part I
Date/Time Prepared:
4/29/2019 2:06 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	31,964,985		31,964,985	0	31,964,985	30.00
31.00	03100	INTENSIVE CARE UNIT	8,283,863		8,283,863	0	8,283,863	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
43.00	04300	NURSERY	2,267,626		2,267,626	0	2,267,626	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,606,389		9,606,389	0	9,606,389	50.00
51.00	05100	RECOVERY ROOM	2,721,302		2,721,302	0	2,721,302	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,859,263		3,859,263	0	3,859,263	52.00
53.00	05300	ANESTHESIOLOGY	505,035		505,035	0	505,035	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,932,371		11,932,371	0	11,932,371	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	10,401,328		10,401,328	0	10,401,328	60.00
65.00	06500	RESPIRATORY THERAPY	2,286,845	0	2,286,845	0	2,286,845	65.00
66.00	06600	PHYSICAL THERAPY	4,070,119	0	4,070,119	0	4,070,119	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,351,132		4,351,132	0	4,351,132	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,032,986		4,032,986	0	4,032,986	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,018,569		6,018,569	0	6,018,569	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,799,287		8,799,287	0	8,799,287	73.00
74.00	07400	RENAL DIALYSIS	1,234,231		1,234,231	0	1,234,231	74.00
76.00	03020	CARDIAC REHAB	0		0	0	0	76.00
76.01	03030	SLEEP LAB	0		0	0	0	76.01
76.02	03951	PSYCH SERVICES	99,756		99,756	0	99,756	76.02
76.03	03952	WOUND CARE	0		0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	12,132,493		12,132,493	0	12,132,493	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,135,032		4,135,032	0	4,135,032	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	285,338		285,338	0	285,338	95.00
101.00	10100	HOME HEALTH AGENCY	0		0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0		0	0	0	116.00
200.00		Subtotal (see instructions)	128,987,950	0	128,987,950	0	128,987,950	200.00
201.00		Less Observation Beds	4,135,032		4,135,032	0	4,135,032	201.00
202.00		Total (see instructions)	124,852,918	0	124,852,918	0	124,852,918	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018Worksheet C
Part I
Date/Time Prepared:
4/29/2019 2:06 pm

			Title XVIII		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	108,286,051		108,286,051		30.00
31.00	03100	INTENSIVE CARE UNIT	26,504,619		26,504,619		31.00
40.00	04000	SUBPROVIDER - IPF	0		0		40.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
43.00	04300	NURSERY	6,622,361		6,622,361		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	123,760,241	98,826,173	222,586,414	0.043158	0.000000
51.00	05100	RECOVERY ROOM	8,984,811	11,813,800	20,798,611	0.130841	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,060,237	1,268,593	11,328,830	0.340659	0.000000
53.00	05300	ANESTHESIOLOGY	4,095,802	2,592,026	6,687,828	0.075516	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	66,523,577	180,633,955	247,157,532	0.048278	0.000000
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000
58.00	05800	MRI	0	0	0	0.000000	0.000000
60.00	06000	LABORATORY	66,471,889	59,770,366	126,242,255	0.082392	0.000000
65.00	06500	RESPIRATORY THERAPY	22,076,038	3,200,444	25,276,482	0.090473	0.000000
66.00	06600	PHYSICAL THERAPY	13,459,657	11,449,260	24,908,917	0.163400	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000
69.00	06900	ELECTROCARDIOLOGY	39,493,854	29,566,062	69,059,916	0.063005	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,380,016	4,248,684	10,628,700	0.379443	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,717,713	13,985,268	36,702,981	0.163980	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	107,353,564	39,220,209	146,573,773	0.060033	0.000000
74.00	07400	RENAL DIALYSIS	6,457,278	215,979	6,673,257	0.184952	0.000000
76.00	03020	CARDIAC REHAB	0	0	0	0.000000	0.000000
76.01	03030	SLEEP LAB	0	0	0	0.000000	0.000000
76.02	03951	PSYCH SERVICES	58,772	435,706	494,478	0.201740	0.000000
76.03	03952	WOUND CARE	0	0	0	0.000000	0.000000
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000
91.00	09100	EMERGENCY	42,453,429	120,481,092	162,934,521	0.074462	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5,936,671	10,724,531	16,661,202	0.248183	0.000000
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0		116.00
200.00		Subtotal (see instructions)	687,696,580	588,432,148	1,276,128,728		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	687,696,580	588,432,148	1,276,128,728		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0084	Period: From 12/01/2017 To 11/30/2018	Worksheet C Part I Date/Time Prepared: 4/29/2019 2:06 pm
			Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio		
			11.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.043158		50.00
51.00	05100	RECOVERY ROOM	0.130841		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.340659		52.00
53.00	05300	ANESTHESIOLOGY	0.075516		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.048278		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.082392		60.00
65.00	06500	RESPIRATORY THERAPY	0.090473		65.00
66.00	06600	PHYSICAL THERAPY	0.163400		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.063005		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.379443		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.163980		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.060033		73.00
74.00	07400	RENAL DIALYSIS	0.184952		74.00
76.00	03020	CARDIAC REHAB	0.000000		76.00
76.01	03030	SLEEP LAB	0.000000		76.01
76.02	03951	PSYCH SERVICES	0.201740		76.02
76.03	03952	WOUND CARE	0.000000		76.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.074462		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.248183		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018Worksheet C
Part I
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				Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	31,964,985		31,964,985	0	31,964,985	30.00	
31.00	03100	INTENSIVE CARE UNIT	8,283,863		8,283,863	0	8,283,863	31.00	
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00	
43.00	04300	NURSERY	2,267,626		2,267,626	0	2,267,626	43.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	9,606,389		9,606,389	0	9,606,389	50.00	
51.00	05100	RECOVERY ROOM	2,721,302		2,721,302	0	2,721,302	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,859,263		3,859,263	0	3,859,263	52.00	
53.00	05300	ANESTHESIOLOGY	505,035		505,035	0	505,035	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,932,371		11,932,371	0	11,932,371	54.00	
54.01	05401	ULTRASOUND	0		0	0	0	54.01	
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00	
57.00	05700	CT SCAN	0		0	0	0	57.00	
58.00	05800	MRI	0		0	0	0	58.00	
60.00	06000	LABORATORY	10,401,328		10,401,328	0	10,401,328	60.00	
65.00	06500	RESPIRATORY THERAPY	2,286,845	0	2,286,845	0	2,286,845	65.00	
66.00	06600	PHYSICAL THERAPY	4,070,119	0	4,070,119	0	4,070,119	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	4,351,132		4,351,132	0	4,351,132	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,032,986		4,032,986	0	4,032,986	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,018,569		6,018,569	0	6,018,569	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	8,799,287		8,799,287	0	8,799,287	73.00	
74.00	07400	RENAL DIALYSIS	1,234,231		1,234,231	0	1,234,231	74.00	
76.00	03020	CARDIAC REHAB	0		0	0	0	76.00	
76.01	03030	SLEEP LAB	0		0	0	0	76.01	
76.02	03951	PSYCH SERVICES	99,756		99,756	0	99,756	76.02	
76.03	03952	WOUND CARE	0		0	0	0	76.03	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00	
90.00	09000	CLINIC	0		0	0	0	90.00	
91.00	09100	EMERGENCY	12,132,493		12,132,493	0	12,132,493	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,135,032		4,135,032	0	4,135,032	92.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	285,338		285,338	0	285,338	95.00	
101.00	10100	HOME HEALTH AGENCY	0		0	0	0	101.00	
SPECIAL PURPOSE COST CENTERS									
116.00	11600	HOSPICE	0		0	0	0	116.00	
200.00		Subtotal (see instructions)	128,987,950	0	128,987,950	0	128,987,950	200.00	
201.00		Less Observation Beds	4,135,032		4,135,032	0	4,135,032	201.00	
202.00		Total (see instructions)	124,852,918	0	124,852,918	0	124,852,918	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0084

Period:
From 12/01/2017
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			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	108,286,051		108,286,051		30.00
31.00	03100	INTENSIVE CARE UNIT	26,504,619		26,504,619		31.00
40.00	04000	SUBPROVIDER - IPF	0		0		40.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
43.00	04300	NURSERY	6,622,361		6,622,361		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	123,760,241	98,826,173	222,586,414	0.043158	0.000000
51.00	05100	RECOVERY ROOM	8,984,811	11,813,800	20,798,611	0.130841	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,060,237	1,268,593	11,328,830	0.340659	0.000000
53.00	05300	ANESTHESIOLOGY	4,095,802	2,592,026	6,687,828	0.075516	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	66,523,577	180,633,955	247,157,532	0.048278	0.000000
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000
58.00	05800	MRI	0	0	0	0.000000	0.000000
60.00	06000	LABORATORY	66,471,889	59,770,366	126,242,255	0.082392	0.000000
65.00	06500	RESPIRATORY THERAPY	22,076,038	3,200,444	25,276,482	0.090473	0.000000
66.00	06600	PHYSICAL THERAPY	13,459,657	11,449,260	24,908,917	0.163400	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000
69.00	06900	ELECTROCARDIOLOGY	39,493,854	29,566,062	69,059,916	0.063005	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,380,016	4,248,684	10,628,700	0.379443	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,717,713	13,985,268	36,702,981	0.163980	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	107,353,564	39,220,209	146,573,773	0.060033	0.000000
74.00	07400	RENAL DIALYSIS	6,457,278	215,979	6,673,257	0.184952	0.000000
76.00	03020	CARDIAC REHAB	0	0	0	0.000000	0.000000
76.01	03030	SLEEP LAB	0	0	0	0.000000	0.000000
76.02	03951	PSYCH SERVICES	58,772	435,706	494,478	0.201740	0.000000
76.03	03952	WOUND CARE	0	0	0	0.000000	0.000000
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000
90.00	09000	CLINIC	0	0	0	0.000000	0.000000
91.00	09100	EMERGENCY	42,453,429	120,481,092	162,934,521	0.074462	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5,936,671	10,724,531	16,661,202	0.248183	0.000000
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000
101.00	10100	HOME HEALTH AGENCY	0	0	0		
	SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0		116.00
200.00		Subtotal (see instructions)	687,696,580	588,432,148	1,276,128,728		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	687,696,580	588,432,148	1,276,128,728		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018Worksheet C
Part I
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Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	05401	ULTRASOUND	0.000000			54.01
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
76.00	03020	CARDIAC REHAB	0.000000			76.00
76.01	03030	SLEEP LAB	0.000000			76.01
76.02	03951	PSYCH SERVICES	0.000000			76.02
76.03	03952	WOUND CARE	0.000000			76.03
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE				116.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018Worksheet D
Part I
Date/Time Prepared:
4/29/2019 2:06 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	3,967,283	0	3,967,283	38,605	102.77	30.00	
31.00	INTENSIVE CARE UNIT	707,893		707,893	4,995	141.72	31.00	
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00	
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00	
43.00	NURSERY	132,020		132,020	3,353	39.37	43.00	
200.00	Total (lines 30 through 199)	4,807,196		4,807,196	46,953		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	14,096	1,448,646					30.00
31.00	INTENSIVE CARE UNIT	2,082	295,061					31.00
40.00	SUBPROVIDER - IPF	0	0					40.00
41.00	SUBPROVIDER - IRF	0	0					41.00
43.00	NURSERY	0	0					43.00
200.00	Total (lines 30 through 199)	16,178	1,743,707					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018Worksheet D
Part II
Date/Time Prepared:
4/29/2019 2:06 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								
50.00	05000	OPERATING ROOM	1,238,852	222,586,414	0.005566	43,501,203	242,128	50.00
51.00	05100	RECOVERY ROOM	176,714	20,798,611	0.008496	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	405,712	11,328,830	0.035812	31,973	1,145	52.00
53.00	05300	ANESTHESIOLOGY	48,175	6,687,828	0.007203	913,712	6,581	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,183,258	247,157,532	0.004787	28,927,995	138,478	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	569,560	126,242,255	0.004512	27,011,377	121,875	60.00
65.00	06500	RESPIRATORY THERAPY	172,951	25,276,482	0.006842	10,767,929	73,674	65.00
66.00	06600	PHYSICAL THERAPY	453,523	24,908,917	0.018207	6,707,582	122,125	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	287,781	69,059,916	0.004167	16,829,912	70,130	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	133,839	10,628,700	0.012592	1,882,644	23,706	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	197,665	36,702,981	0.005386	9,397,277	50,614	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	243,464	146,573,773	0.001661	41,886,564	69,574	73.00
74.00	07400	RENAL DIALYSIS	12,737	6,673,257	0.001909	3,846,895	7,344	74.00
76.00	03020	CARDIAC REHAB	0	0	0.000000	0	0	76.00
76.01	03030	SLEEP LAB	0	0	0.000000	0	0	76.01
76.02	03951	PSYCH SERVICES	1,064	494,478	0.002152	7,762	17	76.02
76.03	03952	WOUND CARE	0	0	0.000000	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	1,063,545	162,934,521	0.006527	16,960,202	110,699	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	513,211	16,661,202	0.030803	2,363,104	72,791	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	6,702,051	1,134,715,697		211,036,131	1,110,881	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0084		Period: From 12/01/2017 To 11/30/2018		Worksheet D Part III Date/Time Prepared: 4/29/2019 2:06 pm		
					Title XVIII		Hospital		PPS		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost				
			1A	1.00	2A	2.00	3.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00		
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	41.00		
43.00	04300	NURSERY	0	0	0	0	0	0	43.00		
200.00	Total (lines 30 through 199)		0	0	0	0	0	0	200.00		
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)		Inpatient Program Days			
			4.00	5.00	6.00	7.00		8.00			
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	38,605	0.00		14,096		30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	4,995	0.00		2,082		31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00		0		40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00		0		41.00	
43.00	04300	NURSERY	0	0	3,353	0.00		0		43.00	
200.00	Total (lines 30 through 199)		0	0	46,953			16,178		200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)								
			9.00								
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0								30.00
31.00	03100	INTENSIVE CARE UNIT	0								31.00
40.00	04000	SUBPROVIDER - IPF	0								40.00
41.00	04100	SUBPROVIDER - IRF	0								41.00
43.00	04300	NURSERY	0								43.00
200.00	Total (lines 30 through 199)		0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018

Worksheet D
Part IV
Date/Time Prepared:
4/29/2019 2:06 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	76.00
76.01	03030	SLEEP LAB	0	0	0	0	76.01
76.02	03951	PSYCH SERVICES	0	0	0	0	76.02
76.03	03952	WOUND CARE	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0084		Period: From 12/01/2017 To 11/30/2018		Worksheet D Part IV Date/Time Prepared: 4/29/2019 2:06 pm	
					Title XVIII		Hospital		PPS	
Cost Center Description					All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
					4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS										
50.00	05000	OPERATING ROOM		0	0	0	222,586,414	0.000000	50.00	
51.00	05100	RECOVERY ROOM		0	0	0	20,798,611	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	11,328,830	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY		0	0	0	6,687,828	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	247,157,532	0.000000	54.00	
54.01	05401	ULTRASOUND		0	0	0	0	0.000000	54.01	
56.00	05600	RADIOISOTOPE		0	0	0	0	0.000000	56.00	
57.00	05700	CT SCAN		0	0	0	0	0.000000	57.00	
58.00	05800	MRI		0	0	0	0	0.000000	58.00	
60.00	06000	LABORATORY		0	0	0	126,242,255	0.000000	60.00	
65.00	06500	RESPIRATORY THERAPY		0	0	0	25,276,482	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY		0	0	0	24,908,917	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY		0	0	0	69,059,916	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	10,628,700	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	36,702,981	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	146,573,773	0.000000	73.00	
74.00	07400	RENAL DIALYSIS		0	0	0	6,673,257	0.000000	74.00	
76.00	03020	CARDIAC REHAB		0	0	0	0	0.000000	76.00	
76.01	03030	SLEEP LAB		0	0	0	0	0.000000	76.01	
76.02	03951	PSYCH SERVICES		0	0	0	494,478	0.000000	76.02	
76.03	03952	WOUND CARE		0	0	0	0	0.000000	76.03	
OUTPATIENT SERVICE COST CENTERS										
88.00	08800	RURAL HEALTH CLINIC		0	0	0	0	0.000000	88.00	
90.00	09000	CLINIC		0	0	0	0	0.000000	90.00	
91.00	09100	EMERGENCY		0	0	0	162,934,521	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	16,661,202	0.000000	92.00	
OTHER REIMBURSABLE COST CENTERS										
95.00	09500	AMBULANCE SERVICES							95.00	
200.00		Total (lines 50 through 199)		0	0	0	1,134,715,697		200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018Worksheet D
Part IV
Date/Time Prepared:
4/29/2019 2:06 pm

				Title XVIII		Hospital	PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	43,501,203	0	28,280,384	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	31,973	0	991	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	913,712	0	502,419	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	28,927,995	0	38,627,876	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	27,011,377	0	6,346,803	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	10,767,929	0	718,494	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	6,707,582	0	158,473	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	16,829,912	0	8,405,839	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,882,644	0	797,070	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	9,397,277	0	5,978,162	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	41,886,564	0	11,772,107	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	3,846,895	0	118,036	0	74.00
76.00	03020	CARDIAC REHAB	0.000000	0	0	0	0	76.00
76.01	03030	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03951	PSYCH SERVICES	0.000000	7,762	0	21,624	0	76.02
76.03	03952	WOUND CARE	0.000000	0	0	0	0	76.03
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	16,960,202	0	13,795,046	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	2,363,104	0	2,426,238	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		211,036,131	0	117,949,562	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018Worksheet D
Part V
Date/Time Prepared:
4/29/2019 2:06 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.043158	28,280,384	0	0	1,220,525	50.00
51.00	05100	RECOVERY ROOM	0.130841	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.340659	991	0	0	338	52.00
53.00	05300	ANESTHESIOLOGY	0.075516	502,419	0	0	37,941	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.048278	38,627,876	0	0	1,864,877	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.082392	6,346,803	0	0	522,926	60.00
65.00	06500	RESPIRATORY THERAPY	0.090473	718,494	0	0	65,004	65.00
66.00	06600	PHYSICAL THERAPY	0.163400	158,473	0	0	25,894	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.063005	8,405,839	0	0	529,610	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.379443	797,070	0	0	302,443	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.163980	5,978,162	0	0	980,299	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.060033	11,772,107	94,907	0	706,715	73.00
74.00	07400	RENAL DIALYSIS	0.184952	118,036	0	0	21,831	74.00
76.00	03020	CARDIAC REHAB	0.000000	0	0	0	0	76.00
76.01	03030	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03951	PSYCH SERVICES	0.201740	21,624	0	0	4,362	76.02
76.03	03952	WOUND CARE	0.000000	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.074462	13,795,046	0	0	1,027,207	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.248183	2,426,238	0	0	602,151	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		117,949,562	94,907	0	7,912,123	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		117,949,562	94,907	0	7,912,123	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018Worksheet D
Part V
Date/Time Prepared:
4/29/2019 2:06 pm

			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,698	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	CARDIAC REHAB	0	0		76.00
76.01	03030	SLEEP LAB	0	0		76.01
76.02	03951	PSYCH SERVICES	0	0		76.02
76.03	03952	WOUND CARE	0	0		76.03
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	5,698	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,698	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0084		Period: From 12/01/2017 To 11/30/2018		Worksheet D Part III Date/Time Prepared: 4/29/2019 2:06 pm		
					Title XIX		Hospital		Cost		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	0	41.00	
43.00	04300	NURSERY	0	0	0	0	0	0	0	43.00	
200.00	Total (lines 30 through 199)		0	0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	38,605	0.00	1,285	30.00			
31.00	03100	INTENSIVE CARE UNIT	0	0	4,995	0.00	154	31.00			
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00			
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00			
43.00	04300	NURSERY	0	0	3,353	0.00	1,452	43.00			
200.00	Total (lines 30 through 199)		0	0	46,953		2,891	200.00			
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0								30.00
31.00	03100	INTENSIVE CARE UNIT	0								31.00
40.00	04000	SUBPROVIDER - IPF	0								40.00
41.00	04100	SUBPROVIDER - IRF	0								41.00
43.00	04300	NURSERY	0								43.00
200.00	Total (lines 30 through 199)		0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018Worksheet D
Part IV
Date/Time Prepared:
4/29/2019 2:06 pm

Cost Center Description		Title XIX		Hospital		Cost	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	76.00
76.01	03030	SLEEP LAB	0	0	0	0	76.01
76.02	03951	PSYCH SERVICES	0	0	0	0	76.02
76.03	03952	WOUND CARE	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018

Worksheet D
Part IV
Date/Time Prepared:
4/29/2019 2:06 pm

Cost Center Description			Title XIX			Hospital	Cost	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	222,586,414	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	20,798,611	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	11,328,830	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	6,687,828	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	247,157,532	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	126,242,255	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	25,276,482	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	24,908,917	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69,059,916	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	10,628,700	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	36,702,981	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	146,573,773	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	6,673,257	0.000000	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0.000000	76.00
76.01	03030	SLEEP LAB	0	0	0	0	0.000000	76.01
76.02	03951	PSYCH SERVICES	0	0	0	494,478	0.000000	76.02
76.03	03952	WOUND CARE	0	0	0	0	0.000000	76.03
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	162,934,521	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	16,661,202	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	1,134,715,697		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018Worksheet D
Part IV
Date/Time Prepared:
4/29/2019 2:06 pm

Cost Center Description		Title XIX			Hospital		Cost	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03020	CARDIAC REHAB	0.000000	0	0	0	0	76.00
76.01	03030	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03951	PSYCH SERVICES	0.000000	0	0	0	0	76.02
76.03	03952	WOUND CARE	0.000000	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0084	Period: From 12/01/2017 To 11/30/2018	Worksheet D-1 Date/Time Prepared: 4/29/2019 2:06 pm
Cost Center Description		Title XVIII	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		38,605	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		38,605	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.		5,911	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		27,700	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)		14,096	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)		31,964,985	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)		31,964,985	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		89,129,830	28.00
29.00	Private room charges (excluding swing-bed charges)		19,163,950	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		69,965,880	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.358634	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		3,242.08	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		2,525.84	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		716.24	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		256.87	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		1,518,359	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		30,446,626	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)		828.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		11,671,488	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		11,671,488	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018

Worksheet D-1

Date/Time Prepared:
4/29/2019 2:06 pm

Cost Center Description		Title XVIII		Hospital		PPS
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	8,283,863	4,995	1,658.43	2,082	3,452,851
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					16,042,346
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					31,166,685
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,743,707
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,110,881
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,854,588
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					28,312,097
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
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
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
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
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
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)					4,994
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					828.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					4,135,032

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018

Worksheet D-1

Date/Time Prepared:
4/29/2019 2:06 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	3,967,283	31,964,985	0.124113	4,135,032	513,211	90.00
91.00	Nursing School cost	0	31,964,985	0.000000	4,135,032	0	91.00
92.00	Allied health cost	0	31,964,985	0.000000	4,135,032	0	92.00
93.00	All other Medical Education	0	31,964,985	0.000000	4,135,032	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0084	Period: From 12/01/2017 To 11/30/2018	Worksheet D-1 Date/Time Prepared: 4/29/2019 2:06 pm
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			38,605 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			38,605 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)			33,611 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)			1,285 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			3,353 15.00
16.00	Nursery days (title V or XIX only)			1,452 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)			31,964,985 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)			31,964,985 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)			31,964,985 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)			828.00 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,063,980 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)			1,063,980 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018

Worksheet D-1

Date/Time Prepared:
4/29/2019 2:06 pm

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)	
Cost Center Description			1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)		2,267,626	3,353	676.30	1,452	981,988	42.00
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT		8,283,863	4,995	1,658.43	154	255,398	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)						2,301,366	49.00
PASS THROUGH COST ADJUSTMENTS								
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
56.00	Target amount (line 54 x line 55)						0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00	Bonus payment (see instructions)						0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00	Relief payment (see instructions)						0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)						4,994	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						828.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						4,135,032	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018

Worksheet D-1

Date/Time Prepared:
4/29/2019 2:06 pm

		Title XIX		Hospital	Cost	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	3,967,283	31,964,985	0.124113	4,135,032	513,211	90.00
91.00 Nursing School cost	0	31,964,985	0.000000	4,135,032	0	91.00
92.00 Allied health cost	0	31,964,985	0.000000	4,135,032	0	92.00
93.00 All other Medical Education	0	31,964,985	0.000000	4,135,032	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0084	Period: From 12/01/2017 To 11/30/2018	Worksheet D-3 Date/Time Prepared: 4/29/2019 2:06 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		46,624,734	30.00
31.00	03100	INTENSIVE CARE UNIT		11,047,571	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.043158	43,501,203	50.00
51.00	05100	RECOVERY ROOM	0.130841	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.340659	31,973	52.00
53.00	05300	ANESTHESIOLOGY	0.075516	913,712	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.048278	28,927,995	54.00
54.01	05401	ULTRASOUND	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	56.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MRI	0.000000	0	58.00
60.00	06000	LABORATORY	0.082392	27,011,377	60.00
65.00	06500	RESPIRATORY THERAPY	0.090473	10,767,929	65.00
66.00	06600	PHYSICAL THERAPY	0.163400	6,707,582	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.063005	16,829,912	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.379443	1,882,644	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.163980	9,397,277	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.060033	41,886,564	73.00
74.00	07400	RENAL DIALYSIS	0.184952	3,846,895	74.00
76.00	03020	CARDIAC REHAB	0.000000	0	76.00
76.01	03030	SLEEP LAB	0.000000	0	76.01
76.02	03951	PSYCH SERVICES	0.201740	7,762	76.02
76.03	03952	WOUND CARE	0.000000	0	76.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000	0	90.00
91.00	09100	EMERGENCY	0.074462	16,960,202	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.248183	2,363,104	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		211,036,131	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)		211,036,131	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0084	Period: From 12/01/2017 To 11/30/2018	Worksheet E Part A Date/Time Prepared: 4/29/2019 2:06 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)		22,617,638	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		4,958,525	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)		388,160	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)		176.32	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 that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		6.57	30.00
31.00	Percentage of Medicaid patient days (see instructions)		33.75	31.00
32.00	Sum of lines 30 and 31		40.32	32.00
33.00	Allowable disproportionate share percentage (see instructions)		22.48	33.00
34.00	Disproportionate share adjustment (see instructions)		1,549,780	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0084	Period: From 12/01/2017 To 11/30/2018	Worksheet E Part A Date/Time Prepared: 4/29/2019 2:06 pm
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,973,963	2,530,146	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,644,068	422,846	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,066,914		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	31,581,017		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)		31,581,017	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,474,246	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		34,055,263	59.00
60.00	Primary payer payments		20,358	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		34,034,905	61.00
62.00	Deductibles billed to program beneficiaries		2,800,896	62.00
63.00	Coinsurance billed to program beneficiaries		198,714	63.00
64.00	Allowable bad debts (see instructions)		963,291	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		626,139	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		879,466	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		31,661,434	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-96,933	70.93
70.94	HRR adjustment amount (see instructions)		-115,576	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0084	Period: From 12/01/2017 To 11/30/2018	Worksheet E Part A Date/Time Prepared: 4/29/2019 2:06 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)		31,448,925	71.00	
71.01	Sequestration adjustment (see instructions)		628,979	71.01	
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	
72.00	Interim payments		30,409,530	72.00	
73.00	Tentative settlement (for contractor use only)		0	73.00	
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		410,416	74.00	
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		3,708,824	75.00	
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00	
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00	
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00	
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00	
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00	
95.00	Time value of money for operating expenses (see instructions)		0	95.00	
96.00	Time value of money for capital related expenses (see instructions)		0	96.00	
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	100.00	
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00	
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00	
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00	
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00	
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00	
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00	
202.00	Medicare discharges (see instructions)			202.00	
203.00	Case-mix adjustment factor (see instructions)			203.00	
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount			204.00	
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00	
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00	
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00	
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00	
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00	
210.00	Reserved for future use			210.00	
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00	
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00	
213.00	Low-volume adjustment (see instructions)			213.00	
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0084	Period: From 12/01/2017 To 11/30/2018	Worksheet E Part B Date/Time Prepared: 4/29/2019 2:06 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		5,698	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		7,912,123	2.00
3.00	OPPS payments		9,958,827	3.00
4.00	Outlier payment (see instructions)		13,464	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		5,698	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		94,907	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)		94,907	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)		94,907	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		89,209	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		5,698	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		9,972,291	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,867,917	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)		8,110,072	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)		8,110,072	30.00
31.00	Primary payer payments		13,724	31.00
32.00	Subtotal (line 30 minus line 31)		8,096,348	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)		508,184	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		330,320	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		471,113	36.00
37.00	Subtotal (see instructions)		8,426,668	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		8,426,668	40.00
40.01	Sequestration adjustment (see instructions)		168,533	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		8,353,382	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-95,247	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018Worksheet E-1
Part I
Date/Time Prepared:
4/29/2019 2:06 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		29,722,271		7,941,539	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		687,259		411,843	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)		30,409,530		8,353,382	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		410,416		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		95,247	6.02	
7.00	Total Medicare program liability (see instructions)		30,819,946		8,258,135	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0084	Period: From 12/01/2017 To 11/30/2018	Worksheet E-1 Part II Date/Time Prepared: 4/29/2019 2:06 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

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

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018

Worksheet G

Date/Time Prepared:
4/29/2019 2:06 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	-2,713,346	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	61,855,620	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-24,375,945	0	0	0	6.00
7.00	Inventory	3,475,608	0	0	0	7.00
8.00	Prepaid expenses	733,412	0	0	0	8.00
9.00	Other current assets	428,940	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)	39,404,289	0	0	0	11.00
FIXED ASSETS						
12.00	Land	11,309,704	0	0	0	12.00
13.00	Land improvements	2,581,275	0	0	0	13.00
14.00	Accumulated depreciation	-1,593,350	0	0	0	14.00
15.00	Buildings	54,549,048	0	0	0	15.00
16.00	Accumulated depreciation	-16,343,717	0	0	0	16.00
17.00	Leasehold improvements	23,428,897	0	0	0	17.00
18.00	Accumulated depreciation	-10,906,324	0	0	0	18.00
19.00	Fixed equipment	5,508,652	0	0	0	19.00
20.00	Accumulated depreciation	-3,661,860	0	0	0	20.00
21.00	Automobiles and trucks	132,378	0	0	0	21.00
22.00	Accumulated depreciation	-127,790	0	0	0	22.00
23.00	Major movable equipment	26,299,762	0	0	0	23.00
24.00	Accumulated depreciation	-24,399,394	0	0	0	24.00
25.00	Minor equipment depreciable	16,974,228	0	0	0	25.00
26.00	Accumulated depreciation	-16,275,649	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)	67,475,860	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	33,555	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	33,555	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	106,913,704	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	24,599,261	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,814,142	0	0	0	38.00
39.00	Payroll taxes payable	539,523	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	-23,244,514	0	0	0	43.00
44.00	Other current liabilities	3,400,421	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	10,108,833	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)	10,108,833	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	96,804,871				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)	96,804,871	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	106,913,704	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018

Worksheet G-1

Date/Time Prepared:
4/29/2019 2:06 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		88,525,091		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		8,279,781				2.00
3.00	Total (sum of line 1 and line 2)		96,804,872		0		3.00
4.00	Additions (credit adjustments) (specify)	0		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)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		96,804,872		0		11.00
12.00	ROUNDING	1		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)		1		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		96,804,871		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	ROUNDING		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018Worksheet G-2
Parts I & II
Date/Time Prepared:
4/29/2019 2:06 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	114,908,412		114,908,412	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	114,908,412		114,908,412	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	26,504,619		26,504,619	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)	26,504,619		26,504,619	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	141,413,031		141,413,031	17.00
18.00	Ancillary services	546,283,549	455,896,179	1,002,179,728	18.00
19.00	Outpatient services	0	132,535,969	132,535,969	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	INDUSTRIAL MEDICINE	0	880,389	880,389	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	687,696,580	589,312,537	1,277,009,117	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		152,635,008		29.00
30.00	ROUNDING	3			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)		3		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)		152,635,011		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0084

Period:
From 12/01/2017
To 11/30/2018

Worksheet G-3

Date/Time Prepared:
4/29/2019 2:06 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,277,009,117	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,116,810,975	2.00
3.00	Net patient revenues (line 1 minus line 2)	160,198,142	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	152,635,011	4.00
5.00	Net income from service to patients (line 3 minus line 4)	7,563,131	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	716,653	24.00
25.00	Total other income (sum of lines 6-24)	716,653	25.00
26.00	Total (line 5 plus line 25)	8,279,784	26.00
27.00	ROUNDING	3	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	3	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	8,279,781	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0084	Period: From 12/01/2017 To 11/30/2018	Worksheet L Parts I-III Date/Time Prepared: 4/29/2019 2:06 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		2,245,492	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		37,887	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)		106.33	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		6.57	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		33.75	8.00
9.00	Sum of lines 7 and 8		40.32	9.00
10.00	Allowable disproportionate share percentage (see instructions)		8.50	10.00
11.00	Disproportionate share adjustment (see instructions)		190,867	11.00
12.00	Total prospective capital payments (see instructions)		2,474,246	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