

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 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0084	Period: From 12/01/2018 To 11/30/2019	Worksheet S Parts I-III Date/Time Prepared: 6/29/2020 4:42 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 6/29/2020	Time: 4:42 pm
	2. ☐ Manually prepared 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 12/01/2018 and ending 11/30/2019 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) JAMES BRACKEN

Officer or Administrator of Provider(s)

INTERIM 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	647,024	-120,715	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	647,024	-120,715	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 12/01/2018 To 11/30/2019		Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 4:42 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 1324 NORTH SHERIDAN ROAD			PO Box:				1.00	
2.00	City: WAUKEGAN			State: IL		Zip Code: 60085-		County: LAKE 2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
								8.00	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			VISTA MEDICAL CENTER - EAST	140084	29404	1	07/01/1966	N P O 3.00
4.00	Subprovider - IPF								4.00
5.00	Subprovider - IRF								5.00
6.00	Subprovider - (Other)								6.00
7.00	Swing Beds - SNF								7.00
8.00	Swing Beds - NF								8.00
9.00	Hospital-Based SNF								9.00
10.00	Hospital-Based NF								10.00
11.00	Hospital-Based OLTC								11.00
12.00	Hospital-Based HHA								12.00
13.00	Separately Certified ASC								13.00
14.00	Hospital-Based Hospice								14.00
15.00	Hospital-Based Health Clinic - RHC								15.00
16.00	Hospital-Based Health Clinic - FQHC								16.00
17.00	Hospital-Based (CMHC) I								17.00
18.00	Renal Dialysis								18.00
19.00	Other								19.00
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						12/01/2018	11/30/2019	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.			1,855	1,746	0	118	9,939	99 24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0084		Period: From 12/01/2018 To 11/30/2019		Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 4:42 pm	
		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	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
				1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.					N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019Worksheet S-2
Part I
Date/Time Prepared:
6/29/2020 4:42 pm

	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019Worksheet S-2
Part I
Date/Time Prepared:
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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	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
			1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS					
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0
	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

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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	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
					1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0084	Period: From 12/01/2018 To 11/30/2019	Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 4:42 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
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		0115.00
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	696,494	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	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	Removed and reserved			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 12/01/2018 To 11/30/2019		Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 4:42 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 1.00	Part B 2.00	Title V 3.00	Title XIX 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	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	N	N	157.00	
158.00	SUBPROVIDER							158.00	
159.00	SNF	N	N	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	N	N	160.00	
161.00	CMHC		N	N	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 0	County 1.00	State 2.00	Zip Code 3.00	CBSA 4.00	FTE/Campus 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)								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 1.00	Ending 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)								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 12/01/2018 To 11/30/2019		Worksheet S-2 Part II Date/Time Prepared: 6/29/2020 4:42 pm	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			Y	03/15/2020	Y	03/15/2020
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019Worksheet S-2
Part II
Date/Time Prepared:
6/29/2020 4:42 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	12/31/2018	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.	TANYA	PICKENS		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) 221-3601	TANYA_PICKENS@QUORUMHEALTH.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0084	Period: From 12/01/2018 To 11/30/2019	Worksheet S-2 Part II Date/Time Prepared: 6/29/2020 4:42 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REVENUE MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019Worksheet S-3
Part I
Date/Time Prepared:
6/29/2020 4:42 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 12/01/2018
To 11/30/2019Worksheet S-3
Part I
Date/Time Prepared:
6/29/2020 4:42 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)	11,214	1,147	31,471			1.00
2.00	HMO and other (see instructions)	4,410	11,902				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)	11,214	1,147	31,471			7.00
8.00	INTENSIVE CARE UNIT	1,329	206	4,118			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		502	3,245			13.00
14.00	Total (see instructions)	12,543	1,855	38,834	0.00	788.88	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	788.88	27.00
28.00	Observation Bed Days		0	4,755			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	37			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 12/01/2018
To 11/30/2019Worksheet S-3
Part I
Date/Time Prepared:
6/29/2020 4:42 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	882	398	10,189	1.00
2.00 HMO and other (see instructions)			0	2,656		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	882	398	10,189	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 12/01/2018
To 11/30/2019Worksheet S-3
Part II
Date/Time Prepared:
6/29/2020 4:42 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	53,875,476	0	53,875,476	1,640,866.00	32.83
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)		711,495	83,574	795,069	25,691.00	30.95
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		912,825	0	912,825	8,376.00	108.98
12.00	Contract labor: Top level management and other management and administrative services		621,404	0	621,404	39,513.00	15.73
13.00	Contract labor: Physician-Part A - Administrative		405,427	0	405,427	6,067.00	66.82
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		2,887,411	0	2,887,411	37,651.00	76.69
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
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		9,007,684	0	9,007,684		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		119,438	0	119,438		
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		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019Worksheet S-3
Part II
Date/Time Prepared:
6/29/2020 4:42 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	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	363,939	0	363,939	8,234.00	44.20	26.00
27.00	Administrative & General	5.00	4,918,266	-83,574	4,834,692	179,146.00	26.99	27.00
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	1,120,309	0	1,120,309	36,823.00	30.42	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	4,141,824	0	4,141,824	98,855.00	41.90	38.00
39.00	Central Services and Supply	14.00	400,333	0	400,333	24,194.00	16.55	39.00
40.00	Pharmacy	15.00	1,934,656	0	1,934,656	44,396.00	43.58	40.00
41.00	Medical Records & Medical Records Library	16.00	780,511	0	780,511	29,765.00	26.22	41.00
42.00	Social Service	17.00	263	0	263	416.00	0.63	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 12/01/2018
To 11/30/2019Worksheet S-3
Part III
Date/Time Prepared:
6/29/2020 4:42 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)	53,875,476	0	53,875,476	1,640,866.00	32.83	1.00
2.00	Excluded area salaries (see instructions)	711,495	83,574	795,069	25,691.00	30.95	2.00
3.00	Subtotal salaries (line 1 minus line 2)	53,163,981	-83,574	53,080,407	1,615,175.00	32.86	3.00
4.00	Subtotal other wages & related costs (see inst.)	4,827,067	0	4,827,067	91,607.00	52.69	4.00
5.00	Subtotal wage-related costs (see inst.)	9,007,684	0	9,007,684	0.00	16.97	5.00
6.00	Total (sum of lines 3 thru 5)	66,998,732	-83,574	66,915,158	1,706,782.00	39.21	6.00
7.00	Total overhead cost (see instructions)	13,660,101	-83,574	13,576,527	421,829.00	32.18	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0084	Period: From 12/01/2018 To 11/30/2019	Worksheet S-3 Part IV Date/Time Prepared: 6/29/2020 4:42 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		909,563	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)		3,718,578	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		45,339	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		30,783	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		-1,319	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		28,259	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		230,432	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		3,154,689	17.00
18.00	Medicare Taxes - Employers Portion Only		737,790	18.00
19.00	Unemployment Insurance		0	19.00
20.00	State or Federal Unemployment Taxes		273,194	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)		9,127,308	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019Worksheet S-3
Part V
Date/Time Prepared:
6/29/2020 4:42 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	912,825	9,127,308	1.00
2.00	Hospital	912,825	9,127,308	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 12/01/2018
To 11/30/2019

Worksheet S-10

Date/Time Prepared:
6/29/2020 4:42 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)		0.098082	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		1,688,340	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		18,444,578	5.00
6.00	Medicaid charges		22,220,557	6.00
7.00	Medicaid cost (line 1 times line 6)		2,179,437	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)		0	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	12,815,747	6,479	12,822,226
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,256,994	635	1,257,629
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	1,256,994	635	1,257,629
			1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		Y	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		6,479	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		9,256,863	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		659,982	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		1,015,356	27.01
28.00	Non-Medicare bad debt expense (see instructions)		8,241,507	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,163,717	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		2,421,346	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,421,346	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019

Worksheet A

Date/Time Prepared:
6/29/2020 4:42 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		3,094,047	3,094,047	3,202,760	6,296,807	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,893,723	2,893,723	752,280	3,646,003	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	363,939	149,857	513,796	4,960,655	5,474,451	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,918,266	34,547,131	39,465,397	-8,724,596	30,740,801	5.00
7.00	00700	OPERATION OF PLANT	1,120,309	4,037,571	5,157,880	-9,767	5,148,113	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	590,157	590,157	0	590,157	8.00
9.00	00900	HOUSEKEEPING	0	2,389,779	2,389,779	-248	2,389,531	9.00
10.00	01000	DIETARY	0	3,469,390	3,469,390	-3,601	3,465,789	10.00
13.00	01300	NURSING ADMINISTRATION	4,141,824	579,764	4,721,588	-3,502	4,718,086	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	400,333	7,234,651	7,634,984	-6,712,788	922,196	14.00
15.00	01500	PHARMACY	1,934,656	4,624,420	6,559,076	-3,943,405	2,615,671	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	780,511	901,328	1,681,839	-7,637	1,674,202	16.00
17.00	01700	SOCIAL SERVICE	263	-2,143	-1,880	0	-1,880	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,179,685	3,633,268	14,812,953	302,080	15,115,033	30.00
31.00	03100	INTENSIVE CARE UNIT	3,171,720	954,664	4,126,384	-2,066	4,124,318	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	867,416	187,621	1,055,037	347,501	1,402,538	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,447,548	4,338,583	6,786,131	-350,878	6,435,253	50.00
51.00	05100	RECOVERY ROOM	1,347,593	133,906	1,481,499	-2,280	1,479,219	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,807,582	852,586	2,660,168	-672,043	1,988,125	52.00
53.00	05300	ANESTHESIOLOGY	43,550	1,153,278	1,196,828	0	1,196,828	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,526,768	2,401,741	4,928,509	2,242,897	7,171,406	54.00
54.01	05401	ULTRASOUND	430,323	111,309	541,632	-541,632	0	54.01
56.00	05600	RADIOISOTOPE	206,298	378,044	584,342	-584,342	0	56.00
57.00	05700	CT SCAN	483,608	434,336	917,944	-917,944	0	57.00
58.00	05800	MRI	125,654	129,550	255,204	-255,204	0	58.00
60.00	06000	LABORATORY	3,511,443	3,825,710	7,337,153	-15,665	7,321,488	60.00
65.00	06500	RESPIRATORY THERAPY	1,117,784	778,751	1,896,535	-207,231	1,689,304	65.00
66.00	06600	PHYSICAL THERAPY	1,592,424	354,908	1,947,332	485,122	2,432,454	66.00
67.00	06700	OCCUPATIONAL THERAPY	201,440	14,817	216,257	-216,257	0	67.00
68.00	06800	SPEECH PATHOLOGY	251,418	20,250	271,668	-271,668	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,489,332	1,245,884	3,735,216	-51,050	3,684,166	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,001,355	4,001,355	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,002,226	3,002,226	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,943,405	3,943,405	73.00
74.00	07400	RENAL DIALYSIS	0	996,181	996,181	0	996,181	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03030	SLEEP LAB	250,843	74,975	325,818	-1,648	324,170	76.01
76.02	03951	PSYCH SERVICES	142,595	83,603	226,198	-58	226,140	76.02
76.03	03952	WOUND CARE	85,742	8,909	94,651	-94,651	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	59,921	23,300	83,221	-20	83,201	90.00
91.00	09100	EMERGENCY	5,163,193	3,985,472	9,148,665	68,299	9,216,964	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	214,837	442,672	657,509	-24,459	633,050	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	53,378,818	91,073,993	144,452,811	-306,060	144,146,751	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	25,885	25,885	-262	25,623	192.00
194.00	07950	CLINIC CORPORATION	0	0	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	0	57,943	57,943	0	57,943	194.01
194.02	07952	MARKETING	0	0	0	307,121	307,121	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	496,658	210,857	707,515	-799	706,716	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	53,875,476	91,368,678	145,244,154	0	145,244,154	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019

Worksheet A

Date/Time Prepared:
6/29/2020 4:42 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	949,585	7,246,392	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-963,822	2,682,181	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-10,503	5,463,948	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-11,921,932	18,818,869	5.00
7.00	00700	OPERATION OF PLANT	0	5,148,113	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	590,157	8.00
9.00	00900	HOUSEKEEPING	0	2,389,531	9.00
10.00	01000	DIETARY	-4,378	3,461,411	10.00
13.00	01300	NURSING ADMINISTRATION	0	4,718,086	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	922,196	14.00
15.00	01500	PHARMACY	0	2,615,671	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-810	1,673,392	16.00
17.00	01700	SOCIAL SERVICE	0	-1,880	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,048,597	13,066,436	30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,124,318	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
43.00	04300	NURSERY	-68,736	1,333,802	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-1,192,920	5,242,333	50.00
51.00	05100	RECOVERY ROOM	0	1,479,219	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-96,826	1,891,299	52.00
53.00	05300	ANESTHESIOLOGY	-894,837	301,991	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,171,406	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	7,321,488	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,689,304	65.00
66.00	06600	PHYSICAL THERAPY	0	2,432,454	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	-179,573	3,504,593	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,001,355	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,002,226	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-5,519	3,937,886	73.00
74.00	07400	RENAL DIALYSIS	0	996,181	74.00
76.00	03020	CARDIAC REHAB	0	0	76.00
76.01	03030	SLEEP LAB	0	324,170	76.01
76.02	03951	PSYCH SERVICES	0	226,140	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	83,201	90.00
91.00	09100	EMERGENCY	-2,417,510	6,799,454	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-285,425	347,625	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)	-19,141,803	125,004,948	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	25,623	192.00
194.00	07950	CLINIC CORPORATION	0	0	194.00
194.01	07951	SENIOR CIRCLE	0	57,943	194.01
194.02	07952	MARKETING	0	307,121	194.02
194.03	07953	VISTA MEDICAL CENTER WEST	0	0	194.03
194.04	07954	OTHER NON-REIMBURSABLE	0	0	194.04
194.05	07955	INDUSTRIAL MEDICINE	0	706,716	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	-19,141,803	126,102,351	200.00

RECLASSIFICATIONS

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019

Worksheet A-6

Date/Time Prepared:
6/29/2020 4:42 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4,966,324		1.00
2.00		0.00	0	0		2.00
	0		0	4,966,324		
	B - RECLASS OXYGEN COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	236,488		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		0	236,488		
	C - RECLASS LEASE AND RENTAL EXP					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	739,064		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
	0		0	739,064		
	D - RECLASS OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	195,112		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3,007,648		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	13,216		3.00
	0		0	3,215,976		
	E - RECLASS MARKETING DEPT.					
1.00	MARKETING	194.02	83,574	223,547		1.00
	0		83,574	223,547		
	F - RECLASS MED. SUPP. CHRGD TO PATIENTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	3,764,867		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	3,002,226		2.00
3.00		0.00	0	0		3.00
	0		0	6,767,093		
	G - RECLASS DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,943,405		1.00
	0		0	3,943,405		
	H - RECLASS LABOR & DELIVERY					
1.00	ADULTS & PEDIATRICS	30.00	240,043	74,039		1.00
2.00	NURSERY	43.00	143,496	210,953		2.00
	0		383,539	284,992		
	I - RECLASS PT, OT, AND SP SERVICES					
1.00	PHYSICAL THERAPY	66.00	452,858	35,047		1.00
2.00		0.00	0	0		2.00
	0		452,858	35,047		
	J - RECLASS MISC SERVICES					
1.00	EMERGENCY	91.00	85,742	7,762		1.00
	0		85,742	7,762		

RECLASSIFICATIONS

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019

Worksheet A-6

Date/Time Prepared:
6/29/2020 4:42 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	K - RECLASS OTHER RADIOLOGY COSTS				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	1,245,883	1,051,998	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	0		1,245,883	1,051,998	
500.00	Grand Total: Increases		2,251,596	21,471,696	500.00

RECLASSIFICATIONS

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019

Worksheet A-6

Date/Time Prepared:
6/29/2020 4:42 pm

Decreases						wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00	10.00		
A - RECLASS EMPLOYEE BENEFITS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,961,965	0		1.00
2.00	EMERGENCY	91.00	0	4,359	0		2.00
	0		0	4,966,324			
B - RECLASS OXYGEN COSTS							
1.00	OPERATING ROOM	50.00	0	101,217	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	131,822	0		2.00
3.00	EMERGENCY	91.00	0	3,449	0		3.00
	0		0	236,488			
C - RECLASS LEASE AND RENTAL EXP							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5,669	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	239,534	0		2.00
3.00	OPERATION OF PLANT	7.00	0	9,767	0		3.00
4.00	HOUSEKEEPING	9.00	0	248	0		4.00
5.00	DIETARY	10.00	0	3,601	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	3,502	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	24,487	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	7,637	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	12,002	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	2,066	0		10.00
11.00	NURSERY	43.00	0	6,948	0		11.00
12.00	OPERATING ROOM	50.00	0	202,910	0		12.00
13.00	RECOVERY ROOM	51.00	0	2,280	0		13.00
14.00	DELIVERY ROOM & LABOR ROOM	52.00	0	3,512	0		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	54,984	0		15.00
16.00	ULTRASOUND	54.01	0	940	0		16.00
17.00	RADIOISOTOPE	56.00	0	152	0		17.00
18.00	MRI	58.00	0	149	0		18.00
19.00	LABORATORY	60.00	0	15,665	0		19.00
20.00	RESPIRATORY THERAPY	65.00	0	75,409	0		20.00
21.00	PHYSICAL THERAPY	66.00	0	2,783	0		21.00
22.00	SPEECH PATHOLOGY	68.00	0	20	0		22.00
23.00	ELECTROCARDIOLOGY	69.00	0	19,009	0		23.00
24.00	SLEEP LAB	76.01	0	1,648	0		24.00
25.00	PSYCH SERVICES	76.02	0	58	0		25.00
26.00	WOUND CARE	76.03	0	1,147	0		26.00
27.00	CLINIC	90.00	0	20	0		27.00
28.00	EMERGENCY	91.00	0	17,397	0		28.00
29.00	AMBULANCE SERVICES	95.00	0	24,459	0		29.00
30.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	262	0		30.00
31.00	INDUSTRIAL MEDICINE	194.05	0	799	0		31.00
	0		0	739,064			
D - RECLASS OTHER CAPITAL COSTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,215,976	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	0		0	3,215,976			
E - RECLASS MARKETING DEPT.							
1.00	ADMINISTRATIVE & GENERAL	5.00	83,574	223,547	0		1.00
	0		83,574	223,547			
F - RECLASS MED. SUPP. CHRGD TO PATIENTS							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	6,688,301	0		1.00
2.00	OPERATING ROOM	50.00	0	46,751	0		2.00
3.00	ELECTROCARDIOLOGY	69.00	0	32,041	0		3.00
	0		0	6,767,093			
G - RECLASS DRUGS CHARGED TO PATIENTS							
1.00	PHARMACY	15.00	0	3,943,405	0		1.00
	0		0	3,943,405			
H - RECLASS LABOR & DELIVERY							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	383,539	284,992	0		1.00
2.00		0.00	0	0	0		2.00
	0		383,539	284,992			
I - RECLASS PT, OT, AND SP SERVICES							
1.00	OCCUPATIONAL THERAPY	67.00	201,440	14,817	0		1.00
2.00	SPEECH PATHOLOGY	68.00	251,418	20,230	0		2.00
	0		452,858	35,047			
J - RECLASS MISC SERVICES							
1.00	WOUND CARE	76.03	85,742	7,762	0		1.00
	0		85,742	7,762			
K - RECLASS OTHER RADIOLOGY COSTS							
1.00	ULTRASOUND	54.01	430,323	110,369	0		1.00
2.00	RADIOISOTOPE	56.00	206,298	377,892	0		2.00
3.00	CT SCAN	57.00	483,608	434,336	0		3.00
4.00	MRI	58.00	125,654	129,401	0		4.00

RECLASSIFICATIONS

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019

Worksheet A-6

Date/Time Prepared:
6/29/2020 4:42 pm

	Decreases				wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other		
	6.00	7.00	8.00	9.00	10.00	
	0		1,245,883	1,051,998		
500.00	Grand Total: Decreases		2,251,596	21,471,696		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019Worksheet A-7
Part I
Date/Time Prepared:
6/29/2020 4:42 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	291,240	0	291,240	0	2.00
3.00	Buildings and Fixtures	96,620,895	9,755	0	9,755	25,264	3.00
4.00	Building Improvements	81,105,636	131,954	0	131,954	85,411	4.00
5.00	Fixed Equipment	5,206,743	81,558	0	81,558	128,990	5.00
6.00	Movable Equipment	35,049,258	1,244,724	0	1,244,724	1,570,641	6.00
7.00	HIT designated Assets	18,504,938	0	0	0	24,786	7.00
8.00	Subtotal (sum of lines 1-7)	237,019,305	1,759,231	0	1,759,231	1,835,092	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	237,019,305	1,759,231	0	1,759,231	1,835,092	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	755,416	0				2.00
3.00	Buildings and Fixtures	96,605,386	0				3.00
4.00	Building Improvements	81,152,179	0				4.00
5.00	Fixed Equipment	5,159,311	0				5.00
6.00	Movable Equipment	34,723,341	0				6.00
7.00	HIT designated Assets	18,480,152	0				7.00
8.00	Subtotal (sum of lines 1-7)	236,943,444	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	236,943,444	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019Worksheet A-7
Part II
Date/Time Prepared:
6/29/2020 4:42 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	3,094,047	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,893,723	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,987,770	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	3,094,047				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,893,723				2.00
3.00	Total (sum of lines 1-2)	0	5,987,770				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019Worksheet A-7
Part III
Date/Time Prepared:
6/29/2020 4:42 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	178,580,641	0	178,580,641	0.753685	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	58,362,804	0	58,362,804	0.246315	0	2.00
3.00	Total (sum of lines 1-2)	236,943,445	0	236,943,445	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	4,043,632	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,929,901	739,064	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,973,533	739,064	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	195,112	3,007,648	0	7,246,392	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	13,216	0	0	2,682,181	2.00
3.00	Total (sum of lines 1-2)	0	208,328	3,007,648	0	9,928,573	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019

Worksheet A-8

Date/Time Prepared:
6/29/2020 4:42 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	-61,859	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-685	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-6,929,320			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	0	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	2,330,701			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-4,378	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	0	MEDICAL RECORDS & LIBRARY	16.00	0	16.00
17.00	Sale of drugs to other than patients	B	-5,519	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-810	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	-4,813	ADMINISTRATIVE & GENERAL	5.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	217,400	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-1,139,193	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	INSERVICE EDUCATION REVENUE	B	0	NURSING ADMINISTRATION	13.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019

Worksheet A-8

Date/Time Prepared:
6/29/2020 4:42 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	-31,568	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	CARELINE REVENUE	B	-13,986	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	RENTAL INCOME	B	-29,107	CAP REL COSTS-BLDG & FIXT	1.00	9	36.00
37.00	OTHER MISC REVENUE	B	-148,556	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	38.00
39.00	MARKETING EXPENSE	A	-213,894	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	NON-ALLOWABLE PHONE / TV	A	-152,438	ADMINISTRATIVE & GENERAL	5.00	0	40.00
40.01	NON-ALLOWABLE TV	A	-15,317	ADMINISTRATIVE & GENERAL	5.00	0	40.01
40.02	NON-ALLOWABLE PHONE DEPR	A	-20,840	CAP REL COSTS-MVBLE EQUIP	2.00	9	40.02
40.03	NON-ALLOWABLE PHONE / TV BENEFITS	A	-10,503	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.03
40.04	TELEPHONE COMMISSIONS	B	-88,300	ADMINISTRATIVE & GENERAL	5.00	0	40.04
40.05	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	40.05
41.00	PHYSICIAN RECRUITING	A	-155,568	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	STATE OPERATING TAX	A	-12,285,540	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	CLUB DUES AND LOBBYING	A	-53,538	ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00	LEGAL FEES	A	-5,747	ADMINISTRATIVE & GENERAL	5.00	0	44.00
44.01	ALLOCATED RECOVERY ROOM	A		RECOVERY ROOM	51.00	0	44.01
44.02	ALLOCATED ANESTHESIA	A		ANESTHESIOLOGY	53.00	0	44.02
44.03	NONALLOWABLE EXPENSE	A	-33,000	ADMINISTRATIVE & GENERAL	5.00	0	44.03
44.04	AMBULANCE TRAINING	B	-285,425	AMBULANCE SERVICES	95.00	0	44.04
45.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.01
45.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.02
45.06	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.06
45.07	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.07
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-19,141,803				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 12/01/2018
To 11/30/2019

Worksheet A-8-1

Date/Time Prepared:
6/29/2020 4:42 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		5.00	ADMINISTRATIVE & GENERAL	DIRECT ALLOCATION - QHR COST	19,085	0 1.00
2.00		5.00	ADMINISTRATIVE & GENERAL	POOLED ALLOCATION OF NON-CAP	1,198,572	0 2.00
3.00		1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	761,292	0 3.00
4.00		2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	196,896	0 4.00
4.01		5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL FUNCTIONAL ALLOC	2,703,996	0 4.01
4.02		5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE COSTS	796,639	-1,811,868 4.02
4.03		5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	5,157,647 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.		5,676,480	3,345,779 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	
	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		100.00	QUORUM HEALTH C	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019

Worksheet A-8-1

Date/Time Prepared:
6/29/2020 4:42 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	19,085	0		1.00
2.00	1,198,572	0		2.00
3.00	761,292	9		3.00
4.00	196,896	9		4.00
4.01	2,703,996	0		4.01
4.02	2,608,507	0		4.02
4.03	-5,157,647	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
5.00	2,330,701			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 12/01/2018
To 11/30/2019

Worksheet A-8-2

Date/Time Prepared:
6/29/2020 4:42 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	30,321	30,321	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	2,048,597	2,048,597	0	0	0	3.00
4.00	43.00	NURSERY	68,736	68,736	0	0	0	4.00
5.00	50.00	OPERATING ROOM	1,192,920	1,192,920	0	0	0	5.00
6.00	52.00	DELIVERY ROOM & LABOR ROOM	96,826	96,826	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	894,837	894,837	0	0	0	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	8.00
9.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	9.00
10.00	69.00	ELECTROCARDIOLOGY	179,573	179,573	0	0	0	10.00
11.00	76.01	SLEEP LAB	0	0	0	0	0	11.00
12.00	90.00	CLINIC	0	0	0	0	0	12.00
13.00	91.00	EMERGENCY	2,417,510	2,417,510	0	0	0	13.00
14.00	95.00	AMBULANCE SERVICES	0	0	0	0	0	14.00
200.00			6,929,320	6,929,320	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	43.00	NURSERY	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	8.00
9.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	9.00
10.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	10.00
11.00	76.01	SLEEP LAB	0	0	0	0	0	11.00
12.00	90.00	CLINIC	0	0	0	0	0	12.00
13.00	91.00	EMERGENCY	0	0	0	0	0	13.00
14.00	95.00	AMBULANCE SERVICES	0	0	0	0	0	14.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	30,321		1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,048,597		3.00
4.00	43.00	NURSERY	0	0	0	68,736		4.00
5.00	50.00	OPERATING ROOM	0	0	0	1,192,920		5.00
6.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	96,826		6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	894,837		7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0		8.00
9.00	65.00	RESPIRATORY THERAPY	0	0	0	0		9.00
10.00	69.00	ELECTROCARDIOLOGY	0	0	0	179,573		10.00
11.00	76.01	SLEEP LAB	0	0	0	0		11.00
12.00	90.00	CLINIC	0	0	0	0		12.00
13.00	91.00	EMERGENCY	0	0	0	2,417,510		13.00
14.00	95.00	AMBULANCE SERVICES	0	0	0	0		14.00
200.00			0	0	0	6,929,320		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019Worksheet B
Part I
Date/Time Prepared:
6/29/2020 4:42 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	7,246,392	7,246,392			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,682,181	2,682,181			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,463,948	111,400	41,234	5,616,582	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,818,869	608,580	225,260	507,449	5.00
7.00	00700	OPERATION OF PLANT	5,148,113	2,040,805	755,383	117,588	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	590,157	124,860	46,216	0	8.00
9.00	00900	HOUSEKEEPING	2,389,531	68,283	25,274	0	9.00
10.00	01000	DIETARY	3,461,411	221,030	81,812	0	10.00
13.00	01300	NURSING ADMINISTRATION	4,718,086	37,480	13,873	434,726	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	922,196	169,970	62,913	42,019	14.00
15.00	01500	PHARMACY	2,615,671	49,989	18,503	203,061	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,673,392	79,408	29,392	81,922	16.00
17.00	01700	SOCIAL SERVICE	-1,880	6,514	2,411	28	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	13,066,436	1,144,504	423,627	1,198,627	30.00
31.00	03100	INTENSIVE CARE UNIT	4,124,318	204,699	75,767	332,904	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	1,333,802	37,406	13,845	106,105	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,242,333	401,099	148,463	256,895	50.00
51.00	05100	RECOVERY ROOM	1,479,219	49,111	18,178	141,443	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,891,299	127,076	47,036	149,468	52.00
53.00	05300	ANESTHESIOLOGY	301,991	13,401	4,960	4,571	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,171,406	377,525	139,737	395,977	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	7,321,488	160,422	59,379	368,561	60.00
65.00	06500	RESPIRATORY THERAPY	1,689,304	53,796	19,912	117,323	65.00
66.00	06600	PHYSICAL THERAPY	2,432,454	159,782	59,142	214,673	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	3,504,593	82,323	30,471	261,280	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,001,355	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,002,226	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,937,886	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	996,181	0	0	0	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	76.00
76.01	03030	SLEEP LAB	324,170	10,798	3,997	26,328	76.01
76.02	03951	PSYCH SERVICES	226,140	0	0	14,967	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	83,201	0	0	6,289	90.00
91.00	09100	EMERGENCY	6,799,454	322,033	119,198	550,928	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	347,625	0	0	22,549	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)	125,004,948	6,662,294	2,465,983	5,555,681	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	3,629	1,343	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	25,623	0	0	0	192.00
194.00	07950	CLINIC CORPORATION	0	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	57,943	3,019	1,118	0	194.01
194.02	07952	MARKETING	307,121	0	0	8,772	194.02
194.03	07953	VISTA MEDICAL CENTER WEST	0	0	0	0	194.03
194.04	07954	OTHER NON-REIMBURSABLE	0	577,450	213,737	0	194.04
194.05	07955	INDUSTRIAL MEDICINE	706,716	0	0	52,129	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)	126,102,351	7,246,392	2,682,181	5,616,582	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019Worksheet B
Part I
Date/Time Prepared:
6/29/2020 4:42 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	20,160,158					5.00
7.00	00700	OPERATION OF PLANT	1,534,129	9,596,018				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	144,858	267,112	1,173,203			8.00
9.00	00900	HOUSEKEEPING	472,517	146,076	0	3,101,681		9.00
10.00	01000	DIETARY	716,315	472,847	0	159,713	5,113,128	10.00
13.00	01300	NURSING ADMINISTRATION	990,321	80,181	0	27,083	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	227,801	363,616	32,293	122,818	0	14.00
15.00	01500	PHARMACY	549,421	106,940	0	36,121	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	354,730	169,876	0	57,379	0	16.00
17.00	01700	SOCIAL SERVICE	1,346	13,936	0	4,707	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,012,958	2,448,426	478,011	827,006	4,521,500	30.00
31.00	03100	INTENSIVE CARE UNIT	901,554	437,911	99,143	147,913	591,628	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	283,758	80,022	12,300	27,029	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,151,048	858,067	107,122	289,829	0	50.00
51.00	05100	RECOVERY ROOM	321,207	105,063	46,820	35,487	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	421,478	271,853	105,017	91,824	0	52.00
53.00	05300	ANESTHESIOLOGY	61,831	28,668	0	9,683	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,538,459	807,636	87,624	272,795	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	1,505,197	343,189	0	115,919	0	60.00
65.00	06500	RESPIRATORY THERAPY	357,816	115,086	3,045	38,872	0	65.00
66.00	06600	PHYSICAL THERAPY	545,392	341,821	263	115,457	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	738,087	176,113	21,515	59,485	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	761,434	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	571,306	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	749,356	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	189,567	0	0	0	0	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03030	SLEEP LAB	69,513	23,100	0	7,802	0	76.01
76.02	03951	PSYCH SERVICES	45,881	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	17,029	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,482,697	688,923	180,050	232,697	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	70,442	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)	19,787,448	8,346,462	1,173,203	2,679,619	5,113,128	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	946	7,764	0	2,622	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,876	0	0	0	0	192.00
194.00	07950	CLINIC CORPORATION	0	0	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	11,813	6,459	0	2,182	0	194.01
194.02	07952	MARKETING	60,113	0	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	150,558	1,235,333	0	417,258	0	194.04
194.05	07955	INDUSTRIAL MEDICINE	144,404	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)	20,160,158	9,596,018	1,173,203	3,101,681	5,113,128	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019Worksheet B
Part I
Date/Time Prepared:
6/29/2020 4:42 pm

Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION	6,301,750					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,943,626				14.00
15.00	01500	PHARMACY	0	19,838	3,599,544			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,443	0	2,447,542		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	27,062	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,714,866	109,100	0	243,002	21,931	30.00
31.00	03100	INTENSIVE CARE UNIT	754,029	63,227	0	44,476	2,870	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	240,329	11,888	0	13,293	2,261	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	581,868	209,777	0	415,899	0	50.00
51.00	05100	RECOVERY ROOM	320,370	3,138	0	38,451	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	338,545	38,350	0	18,725	0	52.00
53.00	05300	ANESTHESIOLOGY	10,353	35,629	0	12,613	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	43,169	0	479,674	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	153,084	0	249,255	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	33,283	0	45,888	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,044	0	48,609	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	60,369	0	139,038	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	566,527	0	19,510	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	469,372	0	64,653	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,599,544	264,419	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	12,203	0	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03030	SLEEP LAB	59,634	1,654	0	10,643	0	76.01
76.02	03951	PSYCH SERVICES	33,900	0	0	1,452	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	1,431	0	2,292	0	90.00
91.00	09100	EMERGENCY	1,247,856	113,027	0	323,447	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	6,901	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)	6,301,750	1,943,251	3,599,544	2,447,542	27,062	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	45	0	0	0	192.00
194.00	07950	CLINIC CORPORATION	0	0	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	0	330	0	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	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	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,301,750	1,943,626	3,599,544	2,447,542	27,062	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019Worksheet B
Part I
Date/Time Prepared:
6/29/2020 4:42 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	30,209,994	0	30,209,994	30.00
31.00	03100	INTENSIVE CARE UNIT	7,780,439	0	7,780,439	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	2,162,038	0	2,162,038	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,662,400	0	9,662,400	50.00
51.00	05100	RECOVERY ROOM	2,558,487	0	2,558,487	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,500,671	0	3,500,671	52.00
53.00	05300	ANESTHESIOLOGY	483,700	0	483,700	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,314,002	0	11,314,002	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	10,276,494	0	10,276,494	60.00
65.00	06500	RESPIRATORY THERAPY	2,474,325	0	2,474,325	65.00
66.00	06600	PHYSICAL THERAPY	3,919,637	0	3,919,637	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	5,073,274	0	5,073,274	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,348,826	0	5,348,826	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,107,557	0	4,107,557	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,551,205	0	8,551,205	73.00
74.00	07400	RENAL DIALYSIS	1,197,951	0	1,197,951	74.00
76.00	03020	CARDIAC REHAB	0	0	0	76.00
76.01	03030	SLEEP LAB	537,639	0	537,639	76.01
76.02	03951	PSYCH SERVICES	322,340	0	322,340	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	110,242	0	110,242	90.00
91.00	09100	EMERGENCY	12,060,310	0	12,060,310	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	447,517	0	447,517	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)	122,099,048	0	122,099,048	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	16,304	0	16,304	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	30,544	0	30,544	192.00
194.00	07950	CLINIC CORPORATION	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	82,864	0	82,864	194.01
194.02	07952	MARKETING	376,006	0	376,006	194.02
194.03	07953	VISTA MEDICAL CENTER WEST	0	0	0	194.03
194.04	07954	OTHER NON-REIMBURSABLE	2,594,336	0	2,594,336	194.04
194.05	07955	INDUSTRIAL MEDICINE	903,249	0	903,249	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)	126,102,351	0	126,102,351	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019Worksheet B
Part II
Date/Time Prepared:
6/29/2020 4:42 pm

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	111,400	41,234	152,634	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	608,580	225,260	833,840	5.00
7.00	00700	OPERATION OF PLANT	0	2,040,805	755,383	2,796,188	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	124,860	46,216	171,076	8.00
9.00	00900	HOUSEKEEPING	0	68,283	25,274	93,557	9.00
10.00	01000	DIETARY	0	221,030	81,812	302,842	10.00
13.00	01300	NURSING ADMINISTRATION	0	37,480	13,873	51,353	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	169,970	62,913	232,883	14.00
15.00	01500	PHARMACY	0	49,989	18,503	68,492	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	79,408	29,392	108,800	16.00
17.00	01700	SOCIAL SERVICE	0	6,514	2,411	8,925	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	1,144,504	423,627	1,568,131	30.00
31.00	03100	INTENSIVE CARE UNIT	0	204,699	75,767	280,466	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	NURSEY	0	37,406	13,845	51,251	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	401,099	148,463	549,562	50.00
51.00	05100	RECOVERY ROOM	0	49,111	18,178	67,289	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	127,076	47,036	174,112	52.00
53.00	05300	ANESTHESIOLOGY	0	13,401	4,960	18,361	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	377,525	139,737	517,262	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	160,422	59,379	219,801	60.00
65.00	06500	RESPIRATORY THERAPY	0	53,796	19,912	73,708	65.00
66.00	06600	PHYSICAL THERAPY	0	159,782	59,142	218,924	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	82,323	30,471	112,794	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	10,798	3,997	14,795	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	171	90.00
91.00	09100	EMERGENCY	0	322,033	119,198	441,231	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	613	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	6,662,294	2,465,983	9,128,277	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	3,629	1,343	4,972	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	CLINIC CORPORATION	0	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	0	3,019	1,118	4,137	194.01
194.02	07952	MARKETING	0	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	577,450	213,737	791,187	194.04
194.05	07955	INDUSTRIAL MEDICINE	0	0	0	1,416	194.05
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	7,246,392	2,682,181	9,928,573	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019Worksheet B
Part II
Date/Time Prepared:
6/29/2020 4:42 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	847,629					5.00
7.00	00700	OPERATION OF PLANT	64,503	2,863,886				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,091	79,718	256,885			8.00
9.00	00900	HOUSEKEEPING	19,867	43,596	0	157,020		9.00
10.00	01000	DIETARY	30,118	141,119	0	8,085	482,164	10.00
13.00	01300	NURSING ADMINISTRATION	41,639	23,930	0	1,371	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,578	108,519	7,071	6,218	0	14.00
15.00	01500	PHARMACY	23,101	31,916	0	1,829	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,915	50,699	0	2,905	0	16.00
17.00	01700	SOCIAL SERVICE	57	4,159	0	238	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	126,665	730,721	104,665	41,868	426,374	30.00
31.00	03100	INTENSIVE CARE UNIT	37,906	130,692	21,708	7,488	55,790	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	11,931	23,882	2,693	1,368	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	48,396	256,086	23,455	14,672	0	50.00
51.00	05100	RECOVERY ROOM	13,505	31,356	10,252	1,797	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,721	81,133	22,995	4,648	0	52.00
53.00	05300	ANESTHESIOLOGY	2,600	8,556	0	490	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	64,685	241,035	19,186	13,810	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	63,287	102,423	0	5,868	0	60.00
65.00	06500	RESPIRATORY THERAPY	15,045	34,347	667	1,968	0	65.00
66.00	06600	PHYSICAL THERAPY	22,931	102,015	58	5,845	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	31,033	52,560	4,711	3,011	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	32,015	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,021	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,507	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	7,970	0	0	0	0	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03030	SLEEP LAB	2,923	6,894	0	395	0	76.01
76.02	03951	PSYCH SERVICES	1,929	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	716	0	0	0	0	90.00
91.00	09100	EMERGENCY	62,341	205,606	39,424	11,780	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	2,962	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)	831,958	2,490,962	256,885	135,654	482,164	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	40	2,317	0	133	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	205	0	0	0	0	192.00
194.00	07950	CLINIC CORPORATION	0	0	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	497	1,928	0	110	0	194.01
194.02	07952	MARKETING	2,527	0	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	6,330	368,679	0	21,123	0	194.04
194.05	07955	INDUSTRIAL MEDICINE	6,072	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)	847,629	2,863,886	256,885	157,020	482,164	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019Worksheet B
Part II
Date/Time Prepared:
6/29/2020 4:42 pm

Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION	130,105					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	365,411				14.00
15.00	01500	PHARMACY	0	3,730	134,586			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	271	0	179,816		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	12,511	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	56,053	20,511	0	17,799	10,139	30.00
31.00	03100	INTENSIVE CARE UNIT	15,567	11,887	0	3,258	1,327	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	4,962	2,235	0	974	1,045	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,013	39,439	0	30,463	0	50.00
51.00	05100	RECOVERY ROOM	6,614	590	0	2,816	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,989	7,210	0	1,372	0	52.00
53.00	05300	ANESTHESIOLOGY	214	6,698	0	924	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,116	0	35,677	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	28,780	0	18,257	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	6,257	0	3,361	0	65.00
66.00	06600	PHYSICAL THERAPY	0	384	0	3,560	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	11,350	0	10,184	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	106,514	0	1,429	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	88,243	0	4,736	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	134,586	19,367	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	894	0	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03030	SLEEP LAB	1,231	311	0	780	0	76.01
76.02	03951	PSYCH SERVICES	700	0	0	106	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	269	0	168	0	90.00
91.00	09100	EMERGENCY	25,762	21,249	0	23,691	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	1,297	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)	130,105	365,341	134,586	179,816	12,511	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	8	0	0	0	192.00
194.00	07950	CLINIC CORPORATION	0	0	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	0	62	0	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	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	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	869	201.00
202.00		TOTAL (sum lines 118 through 201)	130,105	365,411	134,586	179,816	13,380	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019Worksheet B
Part II
Date/Time Prepared:
6/29/2020 4:42 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	3,135,514	0	3,135,514	30.00
31.00	03100	INTENSIVE CARE UNIT	575,135	0	575,135	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	103,224	0	103,224	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	981,066	0	981,066	50.00
51.00	05100	RECOVERY ROOM	138,062	0	138,062	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	320,241	0	320,241	52.00
53.00	05300	ANESTHESIOLOGY	37,967	0	37,967	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	910,531	0	910,531	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	448,431	0	448,431	60.00
65.00	06500	RESPIRATORY THERAPY	138,541	0	138,541	65.00
66.00	06600	PHYSICAL THERAPY	359,550	0	359,550	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	232,743	0	232,743	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	139,958	0	139,958	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	117,000	0	117,000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	185,460	0	185,460	73.00
74.00	07400	RENAL DIALYSIS	8,864	0	8,864	74.00
76.00	03020	CARDIAC REHAB	0	0	0	76.00
76.01	03030	SLEEP LAB	28,044	0	28,044	76.01
76.02	03951	PSYCH SERVICES	3,142	0	3,142	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	1,324	0	1,324	90.00
91.00	09100	EMERGENCY	846,054	0	846,054	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,872	0	4,872	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)	8,715,723	0	8,715,723	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	7,462	0	7,462	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	213	0	213	192.00
194.00	07950	CLINIC CORPORATION	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	6,734	0	6,734	194.01
194.02	07952	MARKETING	2,765	0	2,765	194.02
194.03	07953	VISTA MEDICAL CENTER WEST	0	0	0	194.03
194.04	07954	OTHER NON-REIMBURSABLE	1,187,319	0	1,187,319	194.04
194.05	07955	INDUSTRIAL MEDICINE	7,488	0	7,488	194.05
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	869	0	869	201.00
202.00		TOTAL (sum lines 118 through 201)	9,928,573	0	9,928,573	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019

Worksheet B-1

Date/Time Prepared:
6/29/2020 4:42 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		487,213				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,490	7,490	53,511,537			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	40,918	40,918	4,834,692	-20,160,158	105,942,193	5.00
7.00	00700	OPERATION OF PLANT	137,214	137,214	1,120,309	0	8,061,889	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,395	8,395	0	0	761,233	8.00
9.00	00900	HOUSEKEEPING	4,591	4,591	0	0	2,483,088	9.00
10.00	01000	DIETARY	14,861	14,861	0	0	3,764,253	10.00
13.00	01300	NURSING ADMINISTRATION	2,520	2,520	4,141,824	0	5,204,165	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,428	11,428	400,333	0	1,197,098	14.00
15.00	01500	PHARMACY	3,361	3,361	1,934,656	0	2,887,224	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,339	5,339	780,511	0	1,864,114	16.00
17.00	01700	SOCIAL SERVICE	438	438	263	0	7,073	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	76,951	76,951	11,419,728	0	15,833,194	30.00
31.00	03100	INTENSIVE CARE UNIT	13,763	13,763	3,171,720	0	4,737,688	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	2,515	1,010,912	0	1,491,158	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	26,968	26,968	2,447,548	0	6,048,790	50.00
51.00	05100	RECOVERY ROOM	3,302	3,302	1,347,593	0	1,687,951	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,544	8,544	1,424,043	0	2,214,879	52.00
53.00	05300	ANESTHESIOLOGY	901	901	43,550	0	324,923	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,383	25,383	3,772,651	0	8,084,645	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	10,786	3,511,443	0	7,909,850	60.00
65.00	06500	RESPIRATORY THERAPY	3,617	3,617	1,117,784	0	1,880,335	65.00
66.00	06600	PHYSICAL THERAPY	10,743	10,743	2,045,282	0	2,866,051	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	5,535	2,489,332	0	3,878,667	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	4,001,355	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,002,226	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,937,886	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	996,181	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03030	SLEEP LAB	726	726	250,843	0	365,293	76.01
76.02	03951	PSYCH SERVICES	0	0	142,595	0	241,107	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	59,921	0	89,490	90.00
91.00	09100	EMERGENCY	21,652	21,652	5,248,935	0	7,791,613	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	214,837	0	370,174	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)	447,941	447,941	52,931,305	-20,160,158	103,983,593	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	244	244	0	0	4,972	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	25,623	192.00
194.00	07950	CLINIC CORPORATION	0	0	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	203	203	0	0	62,080	194.01
194.02	07952	MARKETING	0	0	83,574	0	315,893	194.02
194.03	07953	VISTA MEDICAL CENTER WEST	0	0	0	0	0	194.03
194.04	07954	OTHER NON-REIMBURSABLE	38,825	38,825	0	0	791,187	194.04
194.05	07955	INDUSTRIAL MEDICINE	0	0	496,658	0	758,845	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)	7,246,392	2,682,181	5,616,582		20,160,158	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.873150	5.505151	0.104960		0.190294	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019

Worksheet B-1

Date/Time Prepared:
6/29/2020 4:42 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)			152,634		847,629	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002852		0.008001	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 12/01/2018
To 11/30/2019

Worksheet B-1

Date/Time Prepared:
6/29/2020 4:42 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	939,673				8.00
9.00	00900	HOUSEKEEPING	4,591	0	288,605			9.00
10.00	01000	DIETARY	14,861	0	14,861	104,185		10.00
13.00	01300	NURSING ADMINISTRATION	2,520	0	2,520	0	26,507,467	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,428	25,865	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	382,862	76,951	92,130	11,419,728	30.00
31.00	03100	INTENSIVE CARE UNIT	13,763	79,408	13,763	12,055	3,171,720	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	9,852	2,515	0	1,010,912	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	26,968	85,799	26,968	0	2,447,548	50.00
51.00	05100	RECOVERY ROOM	3,302	37,500	3,302	0	1,347,593	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,544	84,113	8,544	0	1,424,043	52.00
53.00	05300	ANESTHESIOLOGY	901	0	901	0	43,550	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,383	70,182	25,383	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	2,439	3,617	0	0	65.00
66.00	06600	PHYSICAL THERAPY	10,743	211	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	17,232	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	726	0	726	0	250,843	76.01
76.02	03951	PSYCH SERVICES	0	0	0	0	142,595	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	144,210	21,652	0	5,248,935	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	939,673	249,333	104,185	26,507,467	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	244	0	244	0	0	190.00
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	0	0	194.03
194.04	07954	OTHER NON-REIMBURSABLE	38,825	0	38,825	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)	9,596,018	1,173,203	3,101,681	5,113,128	6,301,750	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	31.817985	1.248523	10.747149	49.077391	0.237735	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,863,886	256,885	157,020	482,164	130,105	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019

Worksheet B-1

Date/Time Prepared:
6/29/2020 4:42 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)	9.495927	0.273377	0.544065	4.627960	0.004908	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 12/01/2018
To 11/30/2019

Worksheet B-1

Date/Time Prepared:
6/29/2020 4:42 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	12,620,672				14.00
15.00	01500	PHARMACY	128,813	3,943,405			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,367	0	1,244,866,554		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	38,834	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	708,426	0	123,602,475	31,471	30.00
31.00	03100	INTENSIVE CARE UNIT	410,556	0	22,622,745	4,118	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	77,191	0	6,761,228	3,245	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,362,159	0	211,545,680	0	50.00
51.00	05100	RECOVERY ROOM	20,374	0	19,557,825	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	249,022	0	9,524,349	0	52.00
53.00	05300	ANESTHESIOLOGY	231,350	0	6,415,466	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	280,313	0	243,916,334	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	994,035	0	126,783,038	0	60.00
65.00	06500	RESPIRATORY THERAPY	216,118	0	23,340,660	0	65.00
66.00	06600	PHYSICAL THERAPY	13,272	0	24,724,656	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	391,999	0	70,721,239	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,678,667	0	9,923,559	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,047,810	0	32,885,757	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,943,405	134,496,031	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	6,207,025	0	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	76.00
76.01	03030	SLEEP LAB	10,742	0	5,413,737	0	76.01
76.02	03951	PSYCH SERVICES	0	0	738,358	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	9,290	0	1,165,910	0	90.00
91.00	09100	EMERGENCY	733,925	0	164,520,482	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	44,811	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)	12,618,240	3,943,405	1,244,866,554	38,834	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	291	0	0	0	192.00
194.00	07950	CLINIC CORPORATION	0	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	2,141	0	0	0	194.01
194.02	07952	MARKETING	0	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)	1,943,626	3,599,544	2,447,542	27,062	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.154003	0.912801	0.001966	0.696864	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	365,411	134,586	179,816	13,380	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019

Worksheet B-1

Date/Time Prepared:
6/29/2020 4:42 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)	0.028953	0.034129	0.000144	0.322166		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 12/01/2018
To 11/30/2019Worksheet C
Part I
Date/Time Prepared:
6/29/2020 4:42 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	30,209,994		30,209,994	0	30,209,994	30.00	
31.00	03100	INTENSIVE CARE UNIT	7,780,439		7,780,439	0	7,780,439	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	2,162,038		2,162,038	0	2,162,038	43.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	9,662,400		9,662,400	0	9,662,400	50.00	
51.00	05100	RECOVERY ROOM	2,558,487		2,558,487	0	2,558,487	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,500,671		3,500,671	0	3,500,671	52.00	
53.00	05300	ANESTHESIOLOGY	483,700		483,700	0	483,700	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,314,002		11,314,002	0	11,314,002	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	10,276,494		10,276,494	0	10,276,494	60.00	
65.00	06500	RESPIRATORY THERAPY	2,474,325	0	2,474,325	0	2,474,325	65.00	
66.00	06600	PHYSICAL THERAPY	3,919,637	0	3,919,637	0	3,919,637	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	5,073,274		5,073,274	0	5,073,274	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,348,826		5,348,826	0	5,348,826	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,107,557		4,107,557	0	4,107,557	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	8,551,205		8,551,205	0	8,551,205	73.00	
74.00	07400	RENAL DIALYSIS	1,197,951		1,197,951	0	1,197,951	74.00	
76.00	03020	CARDIAC REHAB	0		0	0	0	76.00	
76.01	03030	SLEEP LAB	537,639		537,639	0	537,639	76.01	
76.02	03951	PSYCH SERVICES	322,340		322,340	0	322,340	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	110,242		110,242	0	110,242	90.00	
91.00	09100	EMERGENCY	12,060,310		12,060,310	0	12,060,310	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,965,337		3,965,337	0	3,965,337	92.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	447,517		447,517	0	447,517	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)	126,064,385	0	126,064,385	0	126,064,385	200.00	
201.00		Less Observation Beds	3,965,337		3,965,337	0	3,965,337	201.00	
202.00		Total (see instructions)	122,099,048	0	122,099,048	0	122,099,048	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019Worksheet C
Part I
Date/Time Prepared:
6/29/2020 4:42 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	105,718,726		105,718,726			30.00
31.00	03100	INTENSIVE CARE UNIT	22,622,745		22,622,745			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
43.00	04300	NURSERY	6,761,228		6,761,228			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	120,245,186	91,300,494	211,545,680	0.045675	0.000000	50.00
51.00	05100	RECOVERY ROOM	8,453,775	11,104,050	19,557,825	0.130817	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,514,051	10,298	9,524,349	0.367550	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	4,024,377	2,391,089	6,415,466	0.075396	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	67,142,873	176,773,461	243,916,334	0.046385	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	67,043,570	59,739,468	126,783,038	0.081056	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	20,459,451	2,881,209	23,340,660	0.106009	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	12,938,896	11,785,760	24,724,656	0.158532	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	43,215,229	27,506,010	70,721,239	0.071736	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,301,938	3,621,621	9,923,559	0.539003	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,293,378	11,592,379	32,885,757	0.124904	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100,094,455	34,401,576	134,496,031	0.063580	0.000000	73.00
74.00	07400	RENAL DIALYSIS	5,938,960	268,065	6,207,025	0.192999	0.000000	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0.000000	0.000000	76.00
76.01	03030	SLEEP LAB	9,239	5,404,498	5,413,737	0.099310	0.000000	76.01
76.02	03951	PSYCH SERVICES	52,394	685,964	738,358	0.436563	0.000000	76.02
76.03	03952	WOUND CARE	0	0	0	0.000000	0.000000	76.03
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
90.00	09000	CLINIC	534,847	631,063	1,165,910	0.094554	0.000000	90.00
91.00	09100	EMERGENCY	37,963,287	126,557,195	164,520,482	0.073306	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,486,603	11,397,146	17,883,749	0.221729	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
	SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	666,815,208	578,051,346	1,244,866,554			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	666,815,208	578,051,346	1,244,866,554			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019Worksheet C
Part I
Date/Time Prepared:
6/29/2020 4:42 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		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	0.045675		50.00
51.00	05100	RECOVERY ROOM	0.130817		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.367550		52.00
53.00	05300	ANESTHESIOLOGY	0.075396		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.046385		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	0.081056		60.00
65.00	06500	RESPIRATORY THERAPY	0.106009		65.00
66.00	06600	PHYSICAL THERAPY	0.158532		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.071736		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.539003		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.124904		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.063580		73.00
74.00	07400	RENAL DIALYSIS	0.192999		74.00
76.00	03020	CARDIAC REHAB	0.000000		76.00
76.01	03030	SLEEP LAB	0.099310		76.01
76.02	03951	PSYCH SERVICES	0.436563		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	0.094554		90.00
91.00	09100	EMERGENCY	0.073306		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.221729		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 12/01/2018
To 11/30/2019Worksheet C
Part I
Date/Time Prepared:
6/29/2020 4:42 pm

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	30,209,994		30,209,994	0	30,209,994	30.00
31.00	03100	INTENSIVE CARE UNIT	7,780,439		7,780,439	0	7,780,439	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	2,162,038		2,162,038	0	2,162,038	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,662,400		9,662,400	0	9,662,400	50.00
51.00	05100	RECOVERY ROOM	2,558,487		2,558,487	0	2,558,487	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,500,671		3,500,671	0	3,500,671	52.00
53.00	05300	ANESTHESIOLOGY	483,700		483,700	0	483,700	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,314,002		11,314,002	0	11,314,002	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	10,276,494		10,276,494	0	10,276,494	60.00
65.00	06500	RESPIRATORY THERAPY	2,474,325	0	2,474,325	0	2,474,325	65.00
66.00	06600	PHYSICAL THERAPY	3,919,637	0	3,919,637	0	3,919,637	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	5,073,274		5,073,274	0	5,073,274	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,348,826		5,348,826	0	5,348,826	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,107,557		4,107,557	0	4,107,557	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,551,205		8,551,205	0	8,551,205	73.00
74.00	07400	RENAL DIALYSIS	1,197,951		1,197,951	0	1,197,951	74.00
76.00	03020	CARDIAC REHAB	0		0	0	0	76.00
76.01	03030	SLEEP LAB	537,639		537,639	0	537,639	76.01
76.02	03951	PSYCH SERVICES	322,340		322,340	0	322,340	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	110,242		110,242	0	110,242	90.00
91.00	09100	EMERGENCY	12,060,310		12,060,310	0	12,060,310	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,965,337		3,965,337	0	3,965,337	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	447,517		447,517	0	447,517	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)	126,064,385	0	126,064,385	0	126,064,385	200.00
201.00		Less Observation Beds	3,965,337		3,965,337	0	3,965,337	201.00
202.00		Total (see instructions)	122,099,048	0	122,099,048	0	122,099,048	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019Worksheet C
Part I
Date/Time Prepared:
6/29/2020 4:42 pm

			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	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	105,718,726		105,718,726		30.00
31.00	03100	INTENSIVE CARE UNIT	22,622,745		22,622,745		31.00
40.00	04000	SUBPROVIDER - IPF	0		0		40.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
43.00	04300	NURSERY	6,761,228		6,761,228		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	120,245,186	91,300,494	211,545,680	0.045675	0.000000
51.00	05100	RECOVERY ROOM	8,453,775	11,104,050	19,557,825	0.130817	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,514,051	10,298	9,524,349	0.367550	0.000000
53.00	05300	ANESTHESIOLOGY	4,024,377	2,391,089	6,415,466	0.075396	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	67,142,873	176,773,461	243,916,334	0.046385	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	67,043,570	59,739,468	126,783,038	0.081056	0.000000
65.00	06500	RESPIRATORY THERAPY	20,459,451	2,881,209	23,340,660	0.106009	0.000000
66.00	06600	PHYSICAL THERAPY	12,938,896	11,785,760	24,724,656	0.158532	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	43,215,229	27,506,010	70,721,239	0.071736	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,301,938	3,621,621	9,923,559	0.539003	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,293,378	11,592,379	32,885,757	0.124904	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	100,094,455	34,401,576	134,496,031	0.063580	0.000000
74.00	07400	RENAL DIALYSIS	5,938,960	268,065	6,207,025	0.192999	0.000000
76.00	03020	CARDIAC REHAB	0	0	0	0.000000	0.000000
76.01	03030	SLEEP LAB	9,239	5,404,498	5,413,737	0.099310	0.000000
76.02	03951	PSYCH SERVICES	52,394	685,964	738,358	0.436563	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	534,847	631,063	1,165,910	0.094554	0.000000
91.00	09100	EMERGENCY	37,963,287	126,557,195	164,520,482	0.073306	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,486,603	11,397,146	17,883,749	0.221729	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)	666,815,208	578,051,346	1,244,866,554		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	666,815,208	578,051,346	1,244,866,554		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019Worksheet C
Part I
Date/Time Prepared:
6/29/2020 4:42 pm

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 12/01/2018
To 11/30/2019Worksheet D
Part I
Date/Time Prepared:
6/29/2020 4:42 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	3,135,514	0	3,135,514	36,226	86.55	30.00
31.00	INTENSIVE CARE UNIT	575,135		575,135	4,118	139.66	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	103,224		103,224	3,245	31.81	43.00
200.00	Total (lines 30 through 199)	3,813,873		3,813,873	43,589		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	11,214	970,572				
31.00	INTENSIVE CARE UNIT	1,329	185,608				
40.00	SUBPROVIDER - IPF	0	0				
41.00	SUBPROVIDER - IRF	0	0				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	12,543	1,156,180				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019Worksheet D
Part II
Date/Time Prepared:
6/29/2020 4:42 pm

Cost Center Description			Title XVIII		Hospital	PPS		
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	981,066	211,545,680	0.004638	34,098,146	158,147	50.00
51.00	05100	RECOVERY ROOM	138,062	19,557,825	0.007059	1,629,674	11,504	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	320,241	9,524,349	0.033623	24,470	823	52.00
53.00	05300	ANESTHESIOLOGY	37,967	6,415,466	0.005918	749,253	4,434	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	910,531	243,916,334	0.003733	25,592,891	95,538	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	448,431	126,783,038	0.003537	22,688,204	80,248	60.00
65.00	06500	RESPIRATORY THERAPY	138,541	23,340,660	0.005936	8,464,468	50,245	65.00
66.00	06600	PHYSICAL THERAPY	359,550	24,724,656	0.014542	5,910,915	85,957	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	232,743	70,721,239	0.003291	14,918,776	49,098	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	139,958	9,923,559	0.014104	1,547,868	21,831	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	117,000	32,885,757	0.003558	7,301,035	25,977	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	185,460	134,496,031	0.001379	32,709,939	45,107	73.00
74.00	07400	RENAL DIALYSIS	8,864	6,207,025	0.001428	2,445,054	3,492	74.00
76.00	03020	CARDIAC REHAB	0	0	0.000000	0	0	76.00
76.01	03030	SLEEP LAB	28,044	5,413,737	0.005180	8,564	44	76.01
76.02	03951	PSYCH SERVICES	3,142	738,358	0.004255	7,478	32	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	1,324	1,165,910	0.001136	0	0	90.00
91.00	09100	EMERGENCY	846,054	164,520,482	0.005143	12,949,391	66,599	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	411,566	17,883,749	0.023013	2,068,151	47,594	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	5,308,544	1,109,763,855		173,114,277	746,670	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0084		Period: From 12/01/2018 To 11/30/2019		Worksheet D Part III Date/Time Prepared: 6/29/2020 4:42 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	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	36,226	0.00	11,214	30.00			
31.00	03100	INTENSIVE CARE UNIT	0	0	4,118	0.00	1,329	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	3,245	0.00	0	43.00			
200.00	Total (lines 30 through 199)		0	0	43,589	0.00	12,543	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 12/01/2018
To 11/30/2019Worksheet D
Part IV
Date/Time Prepared:
6/29/2020 4:42 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					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 12/01/2018 To 11/30/2019		Worksheet D Part IV Date/Time Prepared: 6/29/2020 4:42 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	0	211,545,680	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	19,557,825	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	9,524,349	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	6,415,466	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	243,916,334	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	0	126,783,038	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	23,340,660	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	24,724,656	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	70,721,239	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	9,923,559	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	32,885,757	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	134,496,031	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	6,207,025	0.000000	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	0.000000	76.00
76.01	03030	SLEEP LAB	0	0	0	0	5,413,737	0.000000	76.01
76.02	03951	PSYCH SERVICES	0	0	0	0	738,358	0.000000	76.02
76.03	03952	WOUND CARE	0	0	0	0	0	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0	1,165,910	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0	164,520,482	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	17,883,749	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	0	1,109,763,855		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019Worksheet D
Part IV
Date/Time Prepared:
6/29/2020 4:42 pm

Cost Center Description		Title XVIII			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	34,098,146	0	19,059,287	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	1,629,674	0	1,921,405	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	24,470	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	749,253	0	401,738	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	25,592,891	0	32,386,118	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	22,688,204	0	5,857,228	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	8,464,468	0	658,057	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	5,910,915	0	67,487	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	14,918,776	0	7,593,382	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,547,868	0	579,908	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	7,301,035	0	3,712,894	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	32,709,939	0	7,165,606	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	2,445,054	0	133,169	0	74.00
76.00	03020	CARDIAC REHAB	0.000000	0	0	0	0	76.00
76.01	03030	SLEEP LAB	0.000000	8,564	0	1,420,435	0	76.01
76.02	03951	PSYCH SERVICES	0.000000	7,478	0	39,027	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	79,330	0	90.00
91.00	09100	EMERGENCY	0.000000	12,949,391	0	12,788,154	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	2,068,151	0	1,885,818	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		173,114,277	0	95,749,043	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0084		Period: From 12/01/2018 To 11/30/2019		Worksheet D Part V Date/Time Prepared: 6/29/2020 4:42 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	0.045675	19,059,287	0	0	870,533	50.00	
51.00	05100	RECOVERY ROOM	0.130817	1,921,405	0	0	251,352	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.367550	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.075396	401,738	0	0	30,289	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.046385	32,386,118	0	0	1,502,230	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	0.081056	5,857,228	0	0	474,763	60.00	
65.00	06500	RESPIRATORY THERAPY	0.106009	658,057	0	0	69,760	65.00	
66.00	06600	PHYSICAL THERAPY	0.158532	67,487	0	0	10,699	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	0.071736	7,593,382	0	0	544,719	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.539003	579,908	0	0	312,572	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.124904	3,712,894	0	0	463,755	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.063580	7,165,606	0	49,782	455,589	73.00	
74.00	07400	RENAL DIALYSIS	0.192999	133,169	0	0	25,701	74.00	
76.00	03020	CARDIAC REHAB	0.000000	0	0	0	0	76.00	
76.01	03030	SLEEP LAB	0.099310	1,420,435	0	0	141,063	76.01	
76.02	03951	PSYCH SERVICES	0.436563	39,027	0	0	17,038	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	0.094554	79,330	0	287	7,501	90.00	
91.00	09100	EMERGENCY	0.073306	12,788,154	0	0	937,448	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.221729	1,885,818	0	0	418,141	92.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00	
200.00		Subtotal (see instructions)		95,749,043	0	50,069	6,533,153	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		95,749,043	0	50,069	6,533,153	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019Worksheet D
Part V
Date/Time Prepared:
6/29/2020 4:42 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	0	3,165		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	27		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)	0	3,192		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	3,192		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0084	Period: From 12/01/2018 To 11/30/2019	Worksheet D-1 Date/Time Prepared: 6/29/2020 4:42 pm	
Title XVIII		Hospital	PPS		
Cost Center Description		1.00			
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	36,226	1.00		
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	36,226	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)	31,471	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)	11,214	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)	30,209,994	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)	30,209,994	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)	30,209,994	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)	833.93	38.00		
39.00	Program general inpatient routine service cost (line 9 x line 38)	9,351,691	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)	9,351,691	41.00		

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019

Worksheet D-1

Date/Time Prepared:
6/29/2020 4:42 pm

		Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
	Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT	7,780,439	4,118	1,889.37	1,329	2,510,973
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)					13,476,616
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					25,339,280
	PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,156,180
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					746,670
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,902,850
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					23,436,430
	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)					4,755
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					833.93
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,965,337

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019

Worksheet D-1

Date/Time Prepared:
6/29/2020 4:42 pm

Cost Center Description		Title XVIII		Hospital	PPS	
		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	3,135,514	30,209,994	0.103791	3,965,337	411,566
91.00	Nursing School cost	0	30,209,994	0.000000	3,965,337	0
92.00	Allied health cost	0	30,209,994	0.000000	3,965,337	0
93.00	All other Medical Education	0	30,209,994	0.000000	3,965,337	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0084	Period: From 12/01/2018 To 11/30/2019	Worksheet D-1 Date/Time Prepared: 6/29/2020 4:42 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)			36,226 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			36,226 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)			31,471 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)			1,147 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)			3,245 15.00
16.00	Nursery days (title V or XIX only)			502 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)			30,209,994 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)			30,209,994 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)			30,209,994 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)			833.93 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			956,518 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)			956,518 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019

Worksheet D-1

Date/Time Prepared:
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Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospital 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)	2,162,038	3,245	666.27	502	334,468	42.00	
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT	7,780,439	4,118	1,889.37	206	389,210	43.00	
44.00	CORONARY CARE UNIT						44.00	
45.00	BURN INTENSIVE CARE UNIT						45.00	
46.00	SURGICAL INTENSIVE CARE UNIT						46.00	
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00	
Cost Center Description								
							1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						1,680,196	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)						4,755	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						833.93	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						3,965,337	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019

Worksheet D-1

Date/Time Prepared:
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		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	3,135,514	30,209,994	0.103791	3,965,337	411,566	90.00
91.00 Nursing School cost	0	30,209,994	0.000000	3,965,337	0	91.00
92.00 Allied health cost	0	30,209,994	0.000000	3,965,337	0	92.00
93.00 All other Medical Education	0	30,209,994	0.000000	3,965,337	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0084	Period: From 12/01/2018 To 11/30/2019	Worksheet D-3 Date/Time Prepared: 6/29/2020 4:42 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		39,010,118	30.00
31.00	03100	INTENSIVE CARE UNIT		7,290,009	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	0.045675	34,098,146	1,557,433 50.00
51.00	05100	RECOVERY ROOM	0.130817	1,629,674	213,189 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.367550	24,470	8,994 52.00
53.00	05300	ANESTHESIOLOGY	0.075396	749,253	56,491 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.046385	25,592,891	1,187,126 54.00
54.01	05401	ULTRASOUND	0.000000	0	0 54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0 56.00
57.00	05700	CT SCAN	0.000000	0	0 57.00
58.00	05800	MRI	0.000000	0	0 58.00
60.00	06000	LABORATORY	0.081056	22,688,204	1,839,015 60.00
65.00	06500	RESPIRATORY THERAPY	0.106009	8,464,468	897,310 65.00
66.00	06600	PHYSICAL THERAPY	0.158532	5,910,915	937,069 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.071736	14,918,776	1,070,213 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.539003	1,547,868	834,305 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.124904	7,301,035	911,928 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.063580	32,709,939	2,079,698 73.00
74.00	07400	RENAL DIALYSIS	0.192999	2,445,054	471,893 74.00
76.00	03020	CARDIAC REHAB	0.000000	0	0 76.00
76.01	03030	SLEEP LAB	0.099310	8,564	850 76.01
76.02	03951	PSYCH SERVICES	0.436563	7,478	3,265 76.02
76.03	03952	WOUND CARE	0.000000	0	0 76.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0 88.00
90.00	09000	CLINIC	0.094554	0	0 90.00
91.00	09100	EMERGENCY	0.073306	12,949,391	949,268 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.221729	2,068,151	458,569 92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			
200.00		Total (sum of lines 50 through 94 and 96 through 98)		173,114,277	13,476,616 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net charges (line 200 minus line 201)		173,114,277	13,476,616 202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0084	Period: From 12/01/2018 To 11/30/2019	Worksheet E Part A Date/Time Prepared: 6/29/2020 4:42 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)		18,934,608	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		3,759,415	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)			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
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		76,801	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		0	2.04
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)		176.97	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)		7.51	30.00
31.00	Percentage of Medicaid patient days (see instructions)		35.39	31.00
32.00	Sum of lines 30 and 31		42.90	32.00
33.00	Allowable disproportionate share percentage (see instructions)		24.61	33.00
34.00	Disproportionate share adjustment (see instructions)		1,396,250	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0084	Period: From 12/01/2018 To 11/30/2019	Worksheet E Part A Date/Time Prepared: 6/29/2020 4:42 pm	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	2,530,146	2,131,739		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	2,107,300	355,291		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,462,591			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)	26,629,665			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)		26,629,665		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,015,850		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)		28,645,515		59.00
60.00	Primary payer payments		31,588		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		28,613,927		61.00
62.00	Deductibles billed to program beneficiaries		2,420,204		62.00
63.00	Coinsurance billed to program beneficiaries		128,801		63.00
64.00	Allowable bad debts (see instructions)		688,409		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		447,466		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		656,070		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		26,512,388		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0		70.50
70.87	Demonstration payment adjustment amount before sequestration		0		70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0		70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)				70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		-14,246		70.93
70.94	HRR adjustment amount (see instructions)		-184,908		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0084	Period: From 12/01/2018 To 11/30/2019	Worksheet E Part A Date/Time Prepared: 6/29/2020 4:42 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)		26,313,234	71.00
71.01	Sequestration adjustment (see instructions)		526,265	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		25,139,945	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		647,024	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		3,626,173	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	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0084	Period: From 12/01/2018 To 11/30/2019	Worksheet E Part B Date/Time Prepared: 6/29/2020 4:42 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		3,192	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		6,533,153	2.00
3.00	OPPS payments		7,767,637	3.00
4.00	Outlier payment (see instructions)		2,064	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)		3,192	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		50,069	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)		50,069	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)		50,069	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		46,877	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)		3,192	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)		7,769,701	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)		1,499,590	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)		6,273,303	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)		6,273,303	30.00
31.00	Primary payer payments		3,282	31.00
32.00	Subtotal (line 30 minus line 31)		6,270,021	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)		326,947	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		212,516	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		312,694	36.00
37.00	Subtotal (see instructions)		6,482,537	37.00
38.00	MSP-LCC reconciliation amount from PS&R		225	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)		6,482,312	40.00
40.01	Sequestration adjustment (see instructions)		129,646	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		6,473,381	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		-120,715	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
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 12/01/2018
To 11/30/2019Worksheet E-1
Part I
Date/Time Prepared:
6/29/2020 4:42 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		25,139,945		6,473,381	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		25,139,945		6,473,381	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		647,024		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		120,715	6.02	
7.00	Total Medicare program liability (see instructions)		25,786,969		6,352,666	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 12/01/2018 To 11/30/2019	Worksheet E-1 Part II Date/Time Prepared: 6/29/2020 4:42 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 12/01/2018
To 11/30/2019

Worksheet G

Date/Time Prepared:
6/29/2020 4:42 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	-954,836	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	67,606,187	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-37,958,382	0	0	0	6.00
7.00	Inventory	3,415,637	0	0	0	7.00
8.00	Prepaid expenses	731,519	0	0	0	8.00
9.00	Other current assets	914,447	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)	33,754,572	0	0	0	11.00
FIXED ASSETS						
12.00	Land	10,506,701	0	0	0	12.00
13.00	Land improvements	2,872,515	0	0	0	13.00
14.00	Accumulated depreciation	-1,737,499	0	0	0	14.00
15.00	Buildings	54,033,149	0	0	0	15.00
16.00	Accumulated depreciation	-17,548,308	0	0	0	16.00
17.00	Leasehold improvements	23,568,536	0	0	0	17.00
18.00	Accumulated depreciation	-12,423,058	0	0	0	18.00
19.00	Fixed equipment	5,550,605	0	0	0	19.00
20.00	Accumulated depreciation	-4,002,266	0	0	0	20.00
21.00	Automobiles and trucks	132,378	0	0	0	21.00
22.00	Accumulated depreciation	-132,378	0	0	0	22.00
23.00	Major movable equipment	25,887,067	0	0	0	23.00
24.00	Accumulated depreciation	-23,745,459	0	0	0	24.00
25.00	Minor equipment depreciable	15,863,212	0	0	0	25.00
26.00	Accumulated depreciation	-15,301,719	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)	63,523,476	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	8,120,024	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,120,024	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	105,398,072	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	23,492,854	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,783,159	0	0	0	38.00
39.00	Payroll taxes payable	529,309	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,594,691	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	-35,552,556	0	0	0	43.00
44.00	Other current liabilities	3,197,671	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-1,954,872	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	1,167,022	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)	1,167,022	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-787,850	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	106,185,922				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)	106,185,922	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	105,398,072	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019

Worksheet G-1

Date/Time Prepared:
6/29/2020 4:42 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		96,804,871		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		9,381,056				2.00
3.00	Total (sum of line 1 and line 2)		106,185,927		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)		106,185,927		0		11.00
12.00	ROUNDING	5		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)		5		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		106,185,922		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 12/01/2018
To 11/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
6/29/2020 4:42 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	112,479,954		112,479,954	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)	112,479,954		112,479,954	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	22,622,745		22,622,745	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)	22,622,745		22,622,745	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	135,102,699		135,102,699	17.00
18.00	Ancillary services	486,727,772	439,465,942	926,193,714	18.00
19.00	Outpatient services	44,984,737	138,585,404	183,570,141	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	1,295,652	1,295,652	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	666,815,208	579,346,998	1,246,162,206	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		145,244,154		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		145,244,154		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0084

Period:
From 12/01/2018
To 11/30/2019

Worksheet G-3

Date/Time Prepared:
6/29/2020 4:42 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,246,162,206	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,093,372,731	2.00
3.00	Net patient revenues (line 1 minus line 2)	152,789,475	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	145,244,154	4.00
5.00	Net income from service to patients (line 3 minus line 4)	7,545,321	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	1,835,735	24.00
25.00	Total other income (sum of lines 6-24)	1,835,735	25.00
26.00	Total (line 5 plus line 25)	9,381,056	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	9,381,056	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0084	Period: From 12/01/2018 To 11/30/2019	Worksheet L Parts I-III Date/Time Prepared: 6/29/2020 4:42 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,840,240	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		8,516	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)		97.61	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)		7.51	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		35.39	8.00
9.00	Sum of lines 7 and 8		42.90	9.00
10.00	Allowable disproportionate share percentage (see instructions)		9.08	10.00
11.00	Disproportionate share adjustment (see instructions)		167,094	11.00
12.00	Total prospective capital payments (see instructions)		2,015,850	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