

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 12/01/2019 To 11/30/2020	Worksheet S Parts I-III Date/Time Prepared: 6/30/2021 2:19 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 6/30/2021	Time: 2:19 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 12/01/2019 and ending 11/30/2020 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)

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	880,211	40,611	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	880,211	40,611	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 12/01/2019 To 11/30/2020		Worksheet S-2 Part I Date/Time Prepared: 6/30/2021 2:19 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 1324 NORTH SHERIDAN ROAD			PO Box:				1.00	
2.00	City: WAUKEGAN			State: IL		Zip Code: 60085-		County: LAKE	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			VISTA MEDICAL CENTER - EAST	140084	29404	1	07/01/1966	N
4.00	Subprovider - IPF							P	0
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						12/01/2019	11/30/2020	
21.00	Type of Control (see instructions)						4		
							1.00	2.00	
							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		
22.01	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		
22.02	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		
22.03	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	
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		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
				1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			2,394	3,615	0	88	9,183	339

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0084		Period: From 12/01/2019 To 11/30/2020		Worksheet S-2 Part I Date/Time Prepared: 6/30/2021 2:19 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 12/01/2019
To 11/30/2020Worksheet S-2
Part I
Date/Time Prepared:
6/30/2021 2:19 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 12/01/2019
To 11/30/2020Worksheet S-2
Part I
Date/Time Prepared:
6/30/2021 2:19 pm

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

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			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00	
107.00	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 12/01/2019 To 11/30/2020	Worksheet S-2 Part I Date/Time Prepared: 6/30/2021 2:19 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	780,408	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 12/01/2019 To 11/30/2020		Worksheet S-2 Part I Date/Time Prepared: 6/30/2021 2:19 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 12/01/2019 To 11/30/2020		Worksheet S-2 Part II Date/Time Prepared: 6/30/2021 2:19 pm	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			Y	06/03/2021	Y	06/03/2021
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 12/01/2019
To 11/30/2020Worksheet S-2
Part II
Date/Time Prepared:
6/30/2021 2:19 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	12/31/2019	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.	CLINTON	BALLEW		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) 221-3869	CBALLEW@QHCUS.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0084	Period: From 12/01/2019 To 11/30/2020	Worksheet S-2 Part II Date/Time Prepared: 6/30/2021 2:19 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.	DIRECTOR OF REIMBURSEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0084

Period:
From 12/01/2019
To 11/30/2020Worksheet S-3
Part I
Date/Time Prepared:
6/30/2021 2:19 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	61,122	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	61,122	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	23	8,418	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	69,540	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 12/01/2019
To 11/30/2020Worksheet S-3
Part I
Date/Time Prepared:
6/30/2021 2:19 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)	10,130	1,584	28,903			1.00
2.00	HMO and other (see instructions)	4,564	13,225				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)	10,130	1,584	28,903			7.00
8.00	INTENSIVE CARE UNIT	1,578	319	4,645			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		491	3,183			13.00
14.00	Total (see instructions)	11,708	2,394	36,731	0.00	678.54	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	678.54	27.00
28.00	Observation Bed Days		0	4,362			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	50			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 12/01/2019
To 11/30/2020Worksheet S-3
Part I
Date/Time Prepared:
6/30/2021 2:19 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	2,195	450	8,892	1.00
2.00 HMO and other (see instructions)			838	2,487		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	2,195	450	8,892	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 12/01/2019
To 11/30/2020Worksheet S-3
Part II
Date/Time Prepared:
6/30/2021 2:19 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	51,560,042	0	51,560,042	1,411,372.00	36.53
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)		693,095	84,299	777,394	24,750.00	31.41
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		902,936	0	902,936	11,186.00	80.72
12.00	Contract labor: Top level management and other management and administrative services		693,808	0	693,808	6,682.00	103.83
13.00	Contract labor: Physician-Part A - Administrative		331,018	0	331,018	4,298.00	77.02
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		3,007,501	0	3,007,501	46,477.00	64.71
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)		8,392,530	0	8,392,530		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		141,859	0	141,859		
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 12/01/2019
To 11/30/2020Worksheet S-3
Part II
Date/Time Prepared:
6/30/2021 2:19 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	366,347	0	366,347	7,450.00	49.17	26.00
27.00	Administrative & General	5.00	5,276,794	-84,299	5,192,495	136,299.00	38.10	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	1,145,666	0	1,145,666	35,571.00	32.21	30.00
31.00	Laundry & Linen Service	8.00	1,493	0	1,493	43.00	34.72	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	3,876,263	0	3,876,263	80,226.00	48.32	38.00
39.00	Central Services and Supply	14.00	371,353	0	371,353	21,791.00	17.04	39.00
40.00	Pharmacy	15.00	2,169,769	0	2,169,769	46,678.00	46.48	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	8.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0084

Period:
From 12/01/2019
To 11/30/2020Worksheet S-3
Part III
Date/Time Prepared:
6/30/2021 2:19 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)	51,560,042	0	51,560,042	1,411,372.00	36.53	1.00
2.00	Excluded area salaries (see instructions)	693,095	84,299	777,394	24,750.00	31.41	2.00
3.00	Subtotal salaries (line 1 minus line 2)	50,866,947	-84,299	50,782,648	1,386,622.00	36.62	3.00
4.00	Subtotal other wages & related costs (see inst.)	4,935,263	0	4,935,263	68,643.00	71.90	4.00
5.00	Subtotal wage-related costs (see inst.)	8,392,530	0	8,392,530	0.00	16.53	5.00
6.00	Total (sum of lines 3 thru 5)	64,194,740	-84,299	64,110,441	1,455,265.00	44.05	6.00
7.00	Total overhead cost (see instructions)	13,207,685	-84,299	13,123,386	328,066.00	40.00	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0084

Period:
From 12/01/2019
To 11/30/2020Worksheet S-3
Part IV
Date/Time Prepared:
6/30/2021 2:19 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	878,012	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)	3,321,700	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	26,625	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	26,400	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	-4,696	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	16,039	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	327,285	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	3,010,027	17.00
18.00	Medicare Taxes - Employers Portion Only	703,958	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	230,612	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)	8,535,962	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 12/01/2019
To 11/30/2020Worksheet S-3
Part V
Date/Time Prepared:
6/30/2021 2:19 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	902,936	8,535,962	1.00
2.00	Hospital	902,936	8,535,962	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 12/01/2019
To 11/30/2020

Worksheet S-10

Date/Time Prepared:
6/30/2021 2:19 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)		0.112950	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		47,318,306	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		31,496,781	5.00
6.00	Medicaid charges		330,611,788	6.00
7.00	Medicaid cost (line 1 times line 6)		37,342,601	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)	37,232,454	7,628	37,240,082
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	4,205,406	7,628	4,213,034
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)	4,205,406	7,628	4,213,034
			1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		53,544,642	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		1,202,598	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		1,850,151	27.01
28.00	Non-Medicare bad debt expense (see instructions)		51,694,491	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		6,486,446	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		10,699,480	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		10,699,480	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0084

Period:
From 12/01/2019
To 11/30/2020

Worksheet A

Date/Time Prepared:
6/30/2021 2:19 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati 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		3,020,190	3,020,190	2,743,311	5,763,501	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,461,649	2,461,649	1,151,759	3,613,408	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	366,347	118,375	484,722	4,585,389	5,070,111	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,276,794	45,602,418	50,879,212	-6,171,332	44,707,880	5.00
7.00	00700	OPERATION OF PLANT	1,145,666	3,860,478	5,006,144	-7,396	4,998,748	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,493	565,561	567,054	0	567,054	8.00
9.00	00900	HOUSEKEEPING	0	2,452,583	2,452,583	-334	2,452,249	9.00
10.00	01000	DIETARY	0	3,458,811	3,458,811	-3,886	3,454,925	10.00
13.00	01300	NURSING ADMINISTRATION	3,876,263	623,454	4,499,717	-4,123	4,495,594	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	371,353	5,308,504	5,679,857	-4,805,087	874,770	14.00
15.00	01500	PHARMACY	2,169,769	4,603,984	6,773,753	-4,081,657	2,692,096	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	60,293	60,293	-7,999	52,294	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,658,747	3,772,673	14,431,420	92,402	14,523,822	30.00
31.00	03100	INTENSIVE CARE UNIT	3,010,417	1,476,562	4,486,979	-1,659	4,485,320	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	919,883	205,664	1,125,547	310,322	1,435,869	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,922,452	4,135,696	6,058,148	-718,838	5,339,310	50.00
51.00	05100	RECOVERY ROOM	1,284,977	116,197	1,401,174	-1,853	1,399,321	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,918,796	662,757	2,581,553	-418,202	2,163,351	52.00
53.00	05300	ANESTHESIOLOGY	41,741	1,136,329	1,178,070	0	1,178,070	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,392,747	2,428,386	4,821,133	1,500,796	6,321,929	54.00
54.01	05401	ULTRASOUND	536,104	128,722	664,826	-664,826	0	54.01
56.00	05600	RADIOISOTOPE	196,890	293,839	490,729	-490,729	0	56.00
57.00	05700	CT SCAN	481,059	343,901	824,960	-824,960	0	57.00
58.00	05800	MRI	196,046	165,031	361,077	-361,077	0	58.00
60.00	06000	LABORATORY	3,616,564	3,346,994	6,963,558	-69,148	6,894,410	60.00
65.00	06500	RESPIRATORY THERAPY	1,024,359	1,003,813	2,028,172	-461,182	1,566,990	65.00
66.00	06600	PHYSICAL THERAPY	1,430,552	299,588	1,730,140	481,435	2,211,575	66.00
67.00	06700	OCCUPATIONAL THERAPY	203,062	14,363	217,425	-217,425	0	67.00
68.00	06800	SPEECH PATHOLOGY	247,138	19,221	266,359	-266,359	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,089,999	1,018,341	3,108,340	-228,605	2,879,735	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,792,190	2,792,190	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,164,639	2,164,639	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,912,663	3,912,663	73.00
74.00	07400	RENAL DIALYSIS	0	1,030,699	1,030,699	0	1,030,699	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03030	SLEEP LAB	217,183	69,750	286,933	-1,839	285,094	76.01
76.02	03951	PSYCH SERVICES	127,813	86,191	214,004	-22	213,982	76.02
76.03	03952	WOUND CARE	145,703	13,430	159,133	-159,133	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	51,459	16,386	67,845	-17	67,828	90.00
91.00	09100	EMERGENCY	4,945,571	3,703,419	8,648,990	79,803	8,728,793	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	207,080	360,516	567,596	-153,786	413,810	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)	51,074,027	97,984,768	149,058,795	-306,765	148,752,030	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	27,962	27,962	2,982	30,944	192.00
194.00	07950	CLINIC CORPORATION	0	0	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	0	27,411	27,411	0	27,411	194.01
194.02	07952	MARKETING	0	0	0	304,479	304,479	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	486,015	280,234	766,249	-696	765,553	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	51,560,042	98,320,375	149,880,417	0	149,880,417	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0084

Period:
From 12/01/2019
To 11/30/2020

Worksheet A

Date/Time Prepared:
6/30/2021 2:19 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	203,346	5,966,847	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-861,421	2,751,987	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-10,657	5,059,454	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-17,276,109	27,431,771	5.00
7.00	00700	OPERATION OF PLANT	0	4,998,748	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	567,054	8.00
9.00	00900	HOUSEKEEPING	0	2,452,249	9.00
10.00	01000	DIETARY	-1,649	3,453,276	10.00
13.00	01300	NURSING ADMINISTRATION	-261,946	4,233,648	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	874,770	14.00
15.00	01500	PHARMACY	0	2,692,096	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-13	52,281	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,217,913	12,305,909	30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,485,320	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
43.00	04300	NURSERY	-53,003	1,382,866	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-1,346,320	3,992,990	50.00
51.00	05100	RECOVERY ROOM	0	1,399,321	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-79,583	2,083,768	52.00
53.00	05300	ANESTHESIOLOGY	-916,363	261,707	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,321,929	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	6,894,410	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,566,990	65.00
66.00	06600	PHYSICAL THERAPY	0	2,211,575	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	-181,850	2,697,885	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,792,190	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,164,639	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,912,663	73.00
74.00	07400	RENAL DIALYSIS	0	1,030,699	74.00
76.00	03020	CARDIAC REHAB	0	0	76.00
76.01	03030	SLEEP LAB	0	285,094	76.01
76.02	03951	PSYCH SERVICES	0	213,982	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	67,828	90.00
91.00	09100	EMERGENCY	-2,284,874	6,443,919	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	413,810	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)	-25,288,355	123,463,675	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	30,944	192.00
194.00	07950	CLINIC CORPORATION	0	0	194.00
194.01	07951	SENIOR CIRCLE	0	27,411	194.01
194.02	07952	MARKETING	0	304,479	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	765,553	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	-25,288,355	124,592,062	200.00

RECLASSIFICATIONS

Provider CCN: 14-0084

Period:
From 12/01/2019
To 11/30/2020

Worksheet A-6

Date/Time Prepared:
6/30/2021 2:19 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	4,591,840		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,943		2.00
	0		0	4,594,783		
	B - RECLASS OXYGEN COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	249,523		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	457		2.00
3.00	0	0.00	0	0		3.00
	0		0	249,980		
	C - RECLASS LEASE AND RENTAL EXP					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,139,024		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,482,547		2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	39		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
	0		0	2,621,610		
	D - RECLASS OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	253,378		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,489,933		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	12,735		3.00
	0		0	2,756,046		
	E - RECLASS MARKETING DEPT.					
1.00	MARKETING	194.02	84,299	220,180		1.00
	0		84,299	220,180		
	F - RECLASS MED. SUPP. CHRGD TO PATIENTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,542,667		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,164,639		2.00
3.00	OPERATING ROOM	50.00	0	139,807		3.00
	0		0	4,847,113		
	G - RECLASS DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,912,663		1.00
	0		0	3,912,663		
	H - RECLASS LABOR & DELIVERY					
1.00	ADULTS & PEDIATRICS	30.00	173,098	0		1.00
2.00	NURSERY	43.00	145,714	167,122		2.00
	0		318,812	167,122		
	I - RECLASS PT, OT, AND SP SERVICES					
1.00	PHYSICAL THERAPY	66.00	450,200	33,584		1.00
2.00	0	0.00	0	0		2.00
	0		450,200	33,584		
	J - RECLASS MISC SERVICES					
1.00	EMERGENCY	91.00	145,703	13,430		1.00
	0		145,703	13,430		
	K - RECLASS OTHER RADIOLOGY COSTS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	1,410,099	856,490		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00

RECLASSIFICATIONS

Provider CCN: 14-0084

Period:
From 12/01/2019
To 11/30/2020

Worksheet A-6

Date/Time Prepared:
6/30/2021 2:19 pm

Increases						
Cost Center	Line #	Salary	Other			
2.00	3.00	4.00	5.00			
4.00	0.00	0	0			4.00
		1,410,099	856,490			
500.00	Grand Total: Increases	2,409,113	20,273,001			500.00

RECLASSIFICATIONS

Provider CCN: 14-0084

Period:
From 12/01/2019
To 11/30/2020Worksheet A-6
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	Decreases				Wkst. A-7 Ref.		
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00			
	A - RECLASS EMPLOYEE BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,429	0	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	0	4,593,354	0	2.00	
	0		0	4,594,783			
	B - RECLASS OXYGEN COSTS						
1.00	OPERATING ROOM	50.00	0	91,898	0	1.00	
2.00	RESPIRATORY THERAPY	65.00	0	155,037	0	2.00	
3.00	EMERGENCY	91.00	0	3,045	0	3.00	
	0		0	249,980			
	C - RECLASS LEASE AND RENTAL EXP						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5,022	10	1.00	
2.00	OPERATION OF PLANT	7.00	0	7,396	0	2.00	
3.00	HOUSEKEEPING	9.00	0	334	0	3.00	
4.00	DIETARY	10.00	0	3,886	0	4.00	
5.00	NURSING ADMINISTRATION	13.00	0	4,123	0	5.00	
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	34,095	0	6.00	
7.00	PHARMACY	15.00	0	168,994	0	7.00	
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	7,999	0	8.00	
9.00	ADULTS & PEDIATRICS	30.00	0	9,757	0	9.00	
10.00	INTENSIVE CARE UNIT	31.00	0	1,659	0	10.00	
11.00	NURSERY	43.00	0	2,514	0	11.00	
12.00	OPERATING ROOM	50.00	0	766,747	0	12.00	
13.00	RECOVERY ROOM	51.00	0	1,853	0	13.00	
14.00	DELIVERY ROOM & LABOR ROOM	52.00	0	3,207	0	14.00	
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	765,793	0	15.00	
16.00	ULTRASOUND	54.01	0	515	0	16.00	
17.00	RADIOISOTOPE	56.00	0	87	0	17.00	
18.00	CT SCAN	57.00	0	74,274	0	18.00	
19.00	MRI	58.00	0	127	0	19.00	
20.00	LABORATORY	60.00	0	69,148	0	20.00	
21.00	RESPIRATORY THERAPY	65.00	0	306,145	0	21.00	
22.00	PHYSICAL THERAPY	66.00	0	2,349	0	22.00	
23.00	ELECTROCARDIOLOGY	69.00	0	152,941	0	23.00	
24.00	SLEEP LAB	76.01	0	1,839	0	24.00	
25.00	PSYCH SERVICES	76.02	0	22	0	25.00	
26.00	CLINIC	90.00	0	17	0	26.00	
27.00	EMERGENCY	91.00	0	76,285	0	27.00	
28.00	AMBULANCE SERVICES	95.00	0	153,786	0	28.00	
29.00	INDUSTRIAL MEDICINE	194.05	0	696	0	29.00	
	0		0	2,621,610			
	D - RECLASS OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,756,046	12	1.00	
2.00		0.00	0	0	13	2.00	
3.00		0.00	0	0	12	3.00	
	0		0	2,756,046			
	E - RECLASS MARKETING DEPT.						
1.00	ADMINISTRATIVE & GENERAL	5.00	84,299	220,180	0	1.00	
	0		84,299	220,180			
	F - RECLASS MED. SUPP. CHRGD TO PATIENTS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	4,771,449	0	1.00	
2.00	ELECTROCARDIOLOGY	69.00	0	75,664	0	2.00	
3.00		0.00	0	0	0	3.00	
	0		0	4,847,113			
	G - RECLASS DRUGS CHARGED TO PATIENTS						
1.00	PHARMACY	15.00	0	3,912,663	0	1.00	
	0		0	3,912,663			
	H - RECLASS LABOR & DELIVERY						
1.00	ADULTS & PEDIATRICS	30.00	0	70,939	0	1.00	
2.00	DELIVERY ROOM & LABOR ROOM	52.00	318,812	96,183	0	2.00	
	0		318,812	167,122			
	I - RECLASS PT, OT, AND SP SERVICES						
1.00	OCCUPATIONAL THERAPY	67.00	203,062	14,363	0	1.00	
2.00	SPEECH PATHOLOGY	68.00	247,138	19,221	0	2.00	
	0		450,200	33,584			
	J - RECLASS MISC SERVICES						
1.00	WOUND CARE	76.03	145,703	13,430	0	1.00	
	0		145,703	13,430			
	K - RECLASS OTHER RADIOLOGY COSTS						
1.00	ULTRASOUND	54.01	536,104	128,207	0	1.00	
2.00	RADIOISOTOPE	56.00	196,890	293,752	0	2.00	
3.00	CT SCAN	57.00	481,059	269,627	0	3.00	
4.00	MRI	58.00	196,046	164,904	0	4.00	
	0		1,410,099	856,490			
500.00	Grand Total: Decreases		2,409,113	20,273,001		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0084

Period:
From 12/01/2019
To 11/30/2020Worksheet A-7
Part I
Date/Time Prepared:
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		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	755,416	2,282	0	2,282	0	2.00	
3.00	Buildings and Fixtures	96,605,386	12,972	0	12,972	0	3.00	
4.00	Building Improvements	81,152,179	558,471	0	558,471	71,726	4.00	
5.00	Fixed Equipment	5,159,311	923,596	0	923,596	0	5.00	
6.00	Movable Equipment	34,723,341	1,905,530	0	1,905,530	43,955	6.00	
7.00	HIT designated Assets	18,480,152	130,554	0	130,554	0	7.00	
8.00	Subtotal (sum of lines 1-7)	236,943,444	3,533,405	0	3,533,405	115,681	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	236,943,444	3,533,405	0	3,533,405	115,681	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	757,698	0					
3.00	Buildings and Fixtures	96,618,358	0					
4.00	Building Improvements	81,638,924	0					
5.00	Fixed Equipment	6,082,907	0					
6.00	Movable Equipment	36,584,916	0					
7.00	HIT designated Assets	18,610,706	0					
8.00	Subtotal (sum of lines 1-7)	240,361,168	0					
9.00	Reconciling Items	0	0					
10.00	Total (line 8 minus line 9)	240,361,168	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0084

Period:
From 12/01/2019
To 11/30/2020Worksheet A-7
Part II
Date/Time Prepared:
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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	3,020,190	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,461,649	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,481,839	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	3,020,190				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,461,649				2.00
3.00	Total (sum of lines 1-2)	0	5,481,839				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0084

Period:
From 12/01/2019
To 11/30/2020Worksheet A-7
Part III
Date/Time Prepared:
6/30/2021 2:19 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	179,082,640	0	179,082,640	0.745056	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	61,278,529	0	61,278,529	0.254944	0	2.00
3.00	Total (sum of lines 1-2)	240,361,169	0	240,361,169	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	3,223,536	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,600,228	1,139,024	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,823,764	1,139,024	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	253,378	2,489,933	0	5,966,847	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	12,735	0	0	2,751,987	2.00
3.00	Total (sum of lines 1-2)	0	266,113	2,489,933	0	8,718,834	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0084

Period:
From 12/01/2019
To 11/30/2020

Worksheet A-8

Date/Time Prepared:
6/30/2021 2:19 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	-64,368	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-605	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	-7,117,117			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	-3,181,788			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-1,649	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	0	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-13	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	-2,032	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	-82,407	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-881,736	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 12/01/2019
To 11/30/2020

Worksheet A-8

Date/Time Prepared:
6/30/2021 2:19 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	-16,661	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	CARELINE REVENUE	B	-12,282	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	RENTAL INCOME	B	-21,975	CAP REL COSTS-BLDG & FIXT	1.00	9	36.00
37.00	OTHER MISC REVENUE	B	-178,021	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	38.00
39.00	MARKETING EXPENSE	A	-262,151	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	NON-ALLOWABLE PHONE / TV	A	-109,178	ADMINISTRATIVE & GENERAL	5.00	0	40.00
40.01	NON-ALLOWABLE TV	A	-12,912	ADMINISTRATIVE & GENERAL	5.00	0	40.01
40.02	NON-ALLOWABLE PHONE DEPR	A	-20,312	CAP REL COSTS-MVBLE EQUIP	2.00	9	40.02
40.03	NON-ALLOWABLE PHONE / TV BENEFITS	A	-10,657	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.03
40.04	TELEPHONE COMMISIONS	B	-86,880	ADMINISTRATIVE & GENERAL	5.00	0	40.04
40.05	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	40.05
41.00	PHYSICIAN RECRUITING	A	0	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	STATE OPERATING TAX	A	-12,915,690	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	CLUB DUES AND LOBBYING	A	-47,675	ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00	LEGAL FEES	A	0	ADMINISTRATIVE & GENERAL	5.00	0	44.00
44.01	ALLOCATED RECOVERY ROOM	A	0	RECOVERY ROOM	51.00	0	44.01
44.02	ALLOCATED ANESTHESIA	A	0	ANESTHESIOLOGY	53.00	0	44.02
44.03	NONALLOWABLE EXPENSE	A	-300	ADMINISTRATIVE & GENERAL	5.00	0	44.03
44.04	AMBULANCE TRAINING	B	-261,946	NURSING ADMINISTRATION	13.00	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.)		-25,288,355				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 12/01/2019
To 11/30/2020

Worksheet A-8-1

Date/Time Prepared:
6/30/2021 2:19 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	223,116	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	POOLED ALLOCATION OF NON-CAP	1,088,580	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	307,728	0	3.00
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	41,232	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL FUNCTIONAL ALLOC	2,482,368	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE COSTS	945,229	2,837,096	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	5,432,945	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.			5,088,253	8,270,041	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 12/01/2019
To 11/30/2020

Worksheet A-8-1

Date/Time Prepared:
6/30/2021 2:19 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	223,116	0		1.00
2.00	1,088,580	0		2.00
3.00	307,728	9		3.00
4.00	41,232	9		4.00
4.01	2,482,368	0		4.01
4.02	-1,891,867	0		4.02
4.03	-5,432,945	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
5.00	-3,181,788			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 12/01/2019
To 11/30/2020

Worksheet A-8-2

Date/Time Prepared:
6/30/2021 2:19 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	37,211	37,211	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	2,217,913	2,217,913	0	0	0	3.00
4.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	4.00
5.00	43.00	NURSERY	53,003	53,003	0	0	0	5.00
6.00	50.00	OPERATING ROOM	1,346,320	1,346,320	0	0	0	6.00
7.00	52.00	DELIVERY ROOM & LABOR ROOM	79,583	79,583	0	0	0	7.00
8.00	53.00	ANESTHESIOLOGY	916,363	916,363	0	0	0	8.00
9.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	9.00
10.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	10.00
11.00	69.00	ELECTROCARDIOLOGY	181,850	181,850	0	0	0	11.00
12.00	76.01	SLEEP LAB	0	0	0	0	0	12.00
13.00	90.00	CLINIC	0	0	0	0	0	13.00
14.00	91.00	EMERGENCY	2,284,874	2,284,874	0	0	0	14.00
15.00	95.00	AMBULANCE SERVICES	0	0	0	0	0	15.00
200.00			7,117,117	7,117,117	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	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	4.00
5.00	43.00	NURSERY	0	0	0	0	0	5.00
6.00	50.00	OPERATING ROOM	0	0	0	0	0	6.00
7.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	7.00
8.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	8.00
9.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	9.00
10.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	10.00
11.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	11.00
12.00	76.01	SLEEP LAB	0	0	0	0	0	12.00
13.00	90.00	CLINIC	0	0	0	0	0	13.00
14.00	91.00	EMERGENCY	0	0	0	0	0	14.00
15.00	95.00	AMBULANCE SERVICES	0	0	0	0	0	15.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	37,211		1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,217,913		3.00
4.00	31.00	INTENSIVE CARE UNIT	0	0	0	0		4.00
5.00	43.00	NURSERY	0	0	0	53,003		5.00
6.00	50.00	OPERATING ROOM	0	0	0	1,346,320		6.00
7.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	79,583		7.00
8.00	53.00	ANESTHESIOLOGY	0	0	0	916,363		8.00
9.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0		9.00
10.00	65.00	RESPIRATORY THERAPY	0	0	0	0		10.00
11.00	69.00	ELECTROCARDIOLOGY	0	0	0	181,850		11.00
12.00	76.01	SLEEP LAB	0	0	0	0		12.00
13.00	90.00	CLINIC	0	0	0	0		13.00
14.00	91.00	EMERGENCY	0	0	0	2,284,874		14.00
15.00	95.00	AMBULANCE SERVICES	0	0	0	0		15.00
200.00			0	0	0	7,117,117		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0084

Period:
From 12/01/2019
To 11/30/2020Worksheet B
Part I
Date/Time Prepared:
6/30/2021 2:19 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	5,966,847	5,966,847			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,751,987	2,751,987			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,059,454	91,729	42,307	5,193,490	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	27,431,771	501,118	231,122	526,768	5.00
7.00	00700	OPERATION OF PLANT	4,998,748	1,680,448	775,044	116,226	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	567,054	102,813	47,419	151	8.00
9.00	00900	HOUSEKEEPING	2,452,249	56,225	25,932	0	9.00
10.00	01000	DIETARY	3,453,276	182,001	83,941	0	10.00
13.00	01300	NURSING ADMINISTRATION	4,233,648	30,862	14,234	393,239	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	874,770	139,958	64,550	37,673	14.00
15.00	01500	PHARMACY	2,692,096	41,162	18,984	220,119	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	52,281	65,386	30,157	0	16.00
17.00	01700	SOCIAL SERVICE	0	5,364	2,474	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,305,909	942,411	434,652	1,098,861	30.00
31.00	03100	INTENSIVE CARE UNIT	4,485,320	168,554	77,739	305,401	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	1,382,866	30,801	14,206	108,103	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,992,990	330,274	152,327	195,029	50.00
51.00	05100	RECOVERY ROOM	1,399,321	40,439	18,651	130,358	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,083,768	104,637	48,260	162,315	52.00
53.00	05300	ANESTHESIOLOGY	261,707	11,034	5,089	4,235	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,321,929	310,863	143,374	385,791	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	6,894,410	132,095	60,924	366,893	60.00
65.00	06500	RESPIRATORY THERAPY	1,566,990	44,297	20,430	103,919	65.00
66.00	06600	PHYSICAL THERAPY	2,211,575	131,568	60,681	190,799	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,697,885	67,787	31,264	212,026	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,792,190	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,164,639	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,912,663	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,030,699	0	0	0	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	76.00
76.01	03030	SLEEP LAB	285,094	8,891	4,101	22,033	76.01
76.02	03951	PSYCH SERVICES	213,982	0	0	12,966	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	67,828	0	0	5,220	90.00
91.00	09100	EMERGENCY	6,443,919	265,170	122,300	516,500	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	413,810	0	0	21,008	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)	123,463,675	5,485,887	2,530,162	5,135,633	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	2,988	1,378	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	30,944	0	0	0	192.00
194.00	07950	CLINIC CORPORATION	0	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	27,411	2,486	1,147	0	194.01
194.02	07952	MARKETING	304,479	0	0	8,552	194.02
194.03	07953	VISTA MEDICAL CENTER WEST	0	0	0	0	194.03
194.04	07954	OTHER NON-REIMBURSABLE	0	475,486	219,300	0	194.04
194.05	07955	INDUSTRIAL MEDICINE	765,553	0	0	49,305	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)	124,592,062	5,966,847	2,751,987	5,193,490	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0084

Period:
From 12/01/2019
To 11/30/2020Worksheet B
Part I
Date/Time Prepared:
6/30/2021 2:19 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	28,690,779					5.00
7.00	00700	OPERATION OF PLANT	2,264,856	9,835,322				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	214,636	273,773	1,205,846			8.00
9.00	00900	HOUSEKEEPING	758,218	149,719	0	3,442,343		9.00
10.00	01000	DIETARY	1,112,678	484,639	0	177,255	5,493,790	10.00
13.00	01300	NURSING ADMINISTRATION	1,397,717	82,181	0	30,057	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	334,158	372,684	33,192	136,308	0	14.00
15.00	01500	PHARMACY	889,241	109,607	0	40,088	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	44,225	174,113	0	63,681	0	16.00
17.00	01700	SOCIAL SERVICE	2,345	14,284	0	5,224	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,422,276	2,509,484	491,309	917,836	4,733,140	30.00
31.00	03100	INTENSIVE CARE UNIT	1,506,923	448,831	101,902	164,159	760,650	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	459,518	82,018	12,642	29,998	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,397,309	879,466	110,103	321,661	0	50.00
51.00	05100	RECOVERY ROOM	475,312	107,683	48,123	39,385	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	717,703	278,632	107,940	101,909	0	52.00
53.00	05300	ANESTHESIOLOGY	84,385	29,383	0	10,747	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,142,643	827,777	90,062	302,756	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	2,230,110	351,747	0	128,650	0	60.00
65.00	06500	RESPIRATORY THERAPY	519,250	117,956	3,130	43,142	0	65.00
66.00	06600	PHYSICAL THERAPY	776,233	350,345	270	128,137	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	900,191	180,504	22,114	66,019	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	835,339	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	647,595	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,170,551	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	308,354	0	0	0	0	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03030	SLEEP LAB	95,770	23,676	0	8,659	0	76.01
76.02	03951	PSYCH SERVICES	67,896	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	21,854	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,198,268	706,103	185,059	258,255	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	130,085	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)	28,125,639	8,554,605	1,205,846	2,973,926	5,493,790	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1,306	7,957	0	2,910	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,258	0	0	0	0	192.00
194.00	07950	CLINIC CORPORATION	0	0	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	9,287	6,620	0	2,421	0	194.01
194.02	07952	MARKETING	93,649	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	207,859	1,266,140	0	463,086	0	194.04
194.05	07955	INDUSTRIAL MEDICINE	243,781	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)	28,690,779	9,835,322	1,205,846	3,442,343	5,493,790	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0084

Period:
From 12/01/2019
To 11/30/2020Worksheet B
Part I
Date/Time Prepared:
6/30/2021 2:19 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	6,181,938					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,993,293				14.00
15.00	01500	PHARMACY	0	33,359	4,044,656			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	916	0	430,759		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	29,691	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,657,929	126,494	0	47,391	23,363	30.00
31.00	03100	INTENSIVE CARE UNIT	738,696	99,646	0	10,520	3,755	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	261,476	14,189	0	2,724	2,573	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	471,731	203,876	0	65,326	0	50.00
51.00	05100	RECOVERY ROOM	315,308	3,400	0	6,454	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	392,604	46,416	0	4,090	0	52.00
53.00	05300	ANESTHESIOLOGY	10,242	36,057	0	2,215	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	50,627	0	80,867	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	189,814	0	48,052	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	49,079	0	7,513	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,415	0	8,816	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	41,417	0	20,955	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	509,535	0	3,289	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	432,422	0	9,961	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	4,044,656	51,290	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,524	0	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03030	SLEEP LAB	53,292	2,328	0	1,603	0	76.01
76.02	03951	PSYCH SERVICES	31,363	0	0	214	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	890	0	273	0	90.00
91.00	09100	EMERGENCY	1,249,297	131,099	0	56,682	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	9,504	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)	6,181,938	1,983,483	4,044,656	430,759	29,691	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	0	0	0	0	192.00
194.00	07950	CLINIC CORPORATION	0	0	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	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	9,810	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)	6,181,938	1,993,293	4,044,656	430,759	29,691	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0084

Period:
From 12/01/2019
To 11/30/2020Worksheet B
Part I
Date/Time Prepared:
6/30/2021 2:19 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	30,711,055	0	30,711,055	30.00
31.00	03100	INTENSIVE CARE UNIT	8,872,096	0	8,872,096	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	2,401,114	0	2,401,114	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,120,092	0	8,120,092	50.00
51.00	05100	RECOVERY ROOM	2,584,434	0	2,584,434	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,048,274	0	4,048,274	52.00
53.00	05300	ANESTHESIOLOGY	455,094	0	455,094	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,656,689	0	10,656,689	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	10,402,695	0	10,402,695	60.00
65.00	06500	RESPIRATORY THERAPY	2,475,706	0	2,475,706	65.00
66.00	06600	PHYSICAL THERAPY	3,860,839	0	3,860,839	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,240,162	0	4,240,162	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,140,353	0	4,140,353	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,254,617	0	3,254,617	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,179,160	0	9,179,160	73.00
74.00	07400	RENAL DIALYSIS	1,341,577	0	1,341,577	74.00
76.00	03020	CARDIAC REHAB	0	0	0	76.00
76.01	03030	SLEEP LAB	505,447	0	505,447	76.01
76.02	03951	PSYCH SERVICES	326,421	0	326,421	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	96,065	0	96,065	90.00
91.00	09100	EMERGENCY	12,132,652	0	12,132,652	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	574,407	0	574,407	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)	120,378,949	0	120,378,949	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	16,539	0	16,539	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	40,202	0	40,202	192.00
194.00	07950	CLINIC CORPORATION	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	49,372	0	49,372	194.01
194.02	07952	MARKETING	406,680	0	406,680	194.02
194.03	07953	VISTA MEDICAL CENTER WEST	0	0	0	194.03
194.04	07954	OTHER NON-REIMBURSABLE	2,631,871	0	2,631,871	194.04
194.05	07955	INDUSTRIAL MEDICINE	1,068,449	0	1,068,449	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)	124,592,062	0	124,592,062	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0084

Period:
From 12/01/2019
To 11/30/2020Worksheet B
Part II
Date/Time Prepared:
6/30/2021 2:19 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	91,729	42,307	134,036	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	501,118	231,122	732,240	5.00
7.00	00700	OPERATION OF PLANT	0	1,680,448	775,044	2,455,492	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	102,813	47,419	150,232	8.00
9.00	00900	HOUSEKEEPING	0	56,225	25,932	82,157	9.00
10.00	01000	DIETARY	0	182,001	83,941	265,942	10.00
13.00	01300	NURSING ADMINISTRATION	0	30,862	14,234	45,096	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	139,958	64,550	204,508	14.00
15.00	01500	PHARMACY	0	41,162	18,984	60,146	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	65,386	30,157	95,543	16.00
17.00	01700	SOCIAL SERVICE	0	5,364	2,474	7,838	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	942,411	434,652	1,377,063	30.00
31.00	03100	INTENSIVE CARE UNIT	0	168,554	77,739	246,293	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
43.00	04300	NURSERY	0	30,801	14,206	45,007	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	330,274	152,327	482,601	50.00
51.00	05100	RECOVERY ROOM	0	40,439	18,651	59,090	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	104,637	48,260	152,897	52.00
53.00	05300	ANESTHESIOLOGY	0	11,034	5,089	16,123	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	310,863	143,374	454,237	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	132,095	60,924	193,019	60.00
65.00	06500	RESPIRATORY THERAPY	0	44,297	20,430	64,727	65.00
66.00	06600	PHYSICAL THERAPY	0	131,568	60,681	192,249	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	67,787	31,264	99,051	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	8,891	4,101	12,992	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	135	90.00
91.00	09100	EMERGENCY	0	265,170	122,300	387,470	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	542	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	5,485,887	2,530,162	8,016,049	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	2,988	1,378	4,366	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	2,486	1,147	3,633	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	475,486	219,300	694,786	194.04
194.05	07955	INDUSTRIAL MEDICINE	0	0	0	1,272	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	5,966,847	2,751,987	8,718,834	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0084

Period:
From 12/01/2019
To 11/30/2020Worksheet B
Part II
Date/Time Prepared:
6/30/2021 2:19 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	745,834					5.00
7.00	00700	OPERATION OF PLANT	58,876	2,517,367				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,580	70,073	225,889			8.00
9.00	00900	HOUSEKEEPING	19,710	38,321	0	140,188		9.00
10.00	01000	DIETARY	28,924	124,044	0	7,219	426,129	10.00
13.00	01300	NURSING ADMINISTRATION	36,334	21,034	0	1,224	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,687	95,389	6,218	5,551	0	14.00
15.00	01500	PHARMACY	23,116	28,054	0	1,633	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,150	44,564	0	2,593	0	16.00
17.00	01700	SOCIAL SERVICE	61	3,656	0	213	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	114,966	642,307	92,036	37,376	367,129	30.00
31.00	03100	INTENSIVE CARE UNIT	39,173	114,879	19,089	6,685	59,000	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	11,945	20,993	2,368	1,222	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	36,323	225,101	20,625	13,100	0	50.00
51.00	05100	RECOVERY ROOM	12,356	27,562	9,015	1,604	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,657	71,316	20,220	4,150	0	52.00
53.00	05300	ANESTHESIOLOGY	2,194	7,521	0	438	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	55,699	211,871	16,871	12,330	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	57,972	90,030	0	5,239	0	60.00
65.00	06500	RESPIRATORY THERAPY	13,498	30,191	586	1,757	0	65.00
66.00	06600	PHYSICAL THERAPY	20,178	89,671	51	5,218	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	23,401	46,200	4,143	2,689	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	21,715	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,834	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30,429	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	8,016	0	0	0	0	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03030	SLEEP LAB	2,490	6,060	0	353	0	76.01
76.02	03951	PSYCH SERVICES	1,765	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	568	0	0	0	0	90.00
91.00	09100	EMERGENCY	57,145	180,728	34,667	10,517	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	3,382	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)	731,144	2,189,565	225,889	121,111	426,129	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	34	2,037	0	119	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	241	0	0	0	0	192.00
194.00	07950	CLINIC CORPORATION	0	0	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	241	1,694	0	99	0	194.01
194.02	07952	MARKETING	2,434	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	5,403	324,071	0	18,859	0	194.04
194.05	07955	INDUSTRIAL MEDICINE	6,337	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)	745,834	2,517,367	225,889	140,188	426,129	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0084

Period:
From 12/01/2019
To 11/30/2020Worksheet B
Part II
Date/Time Prepared:
6/30/2021 2:19 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	113,836					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	321,325				14.00
15.00	01500	PHARMACY	0	5,378	124,007			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	148	0	143,998		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	11,768	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	48,937	20,391	0	15,836	9,260	30.00
31.00	03100	INTENSIVE CARE UNIT	13,604	16,063	0	3,515	1,488	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	4,815	2,287	0	910	1,020	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,688	32,866	0	21,829	0	50.00
51.00	05100	RECOVERY ROOM	5,807	548	0	2,157	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,230	7,482	0	1,367	0	52.00
53.00	05300	ANESTHESIOLOGY	189	5,813	0	740	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,161	0	27,078	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	30,599	0	16,057	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	7,912	0	2,511	0	65.00
66.00	06600	PHYSICAL THERAPY	0	389	0	2,946	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	6,677	0	7,002	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	82,138	0	1,099	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	69,708	0	3,329	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	124,007	17,139	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	843	0	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03030	SLEEP LAB	981	375	0	536	0	76.01
76.02	03951	PSYCH SERVICES	578	0	0	72	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	143	0	91	0	90.00
91.00	09100	EMERGENCY	23,007	21,134	0	18,941	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	1,532	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)	113,836	319,744	124,007	143,998	11,768	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	0	0	0	0	192.00
194.00	07950	CLINIC CORPORATION	0	0	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	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	1,581	0	0	0	194.05
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	113,836	321,325	124,007	143,998	11,768	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0084

Period:
From 12/01/2019
To 11/30/2020Worksheet B
Part II
Date/Time Prepared:
6/30/2021 2:19 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	2,753,669	0	2,753,669	30.00
31.00	03100	INTENSIVE CARE UNIT	527,670	0	527,670	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	93,357	0	93,357	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	846,166	0	846,166	50.00
51.00	05100	RECOVERY ROOM	121,503	0	121,503	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	287,508	0	287,508	52.00
53.00	05300	ANESTHESIOLOGY	33,127	0	33,127	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	796,203	0	796,203	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	402,384	0	402,384	60.00
65.00	06500	RESPIRATORY THERAPY	123,864	0	123,864	65.00
66.00	06600	PHYSICAL THERAPY	315,626	0	315,626	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	194,635	0	194,635	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	104,952	0	104,952	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	89,871	0	89,871	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	171,575	0	171,575	73.00
74.00	07400	RENAL DIALYSIS	8,859	0	8,859	74.00
76.00	03020	CARDIAC REHAB	0	0	0	76.00
76.01	03030	SLEEP LAB	24,356	0	24,356	76.01
76.02	03951	PSYCH SERVICES	2,750	0	2,750	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	937	0	937	90.00
91.00	09100	EMERGENCY	746,938	0	746,938	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,456	0	5,456	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)	7,651,406	0	7,651,406	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	6,556	0	6,556	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	241	0	241	192.00
194.00	07950	CLINIC CORPORATION	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	5,667	0	5,667	194.01
194.02	07952	MARKETING	2,655	0	2,655	194.02
194.03	07953	VISTA MEDICAL CENTER WEST	0	0	0	194.03
194.04	07954	OTHER NON-REIMBURSABLE	1,043,119	0	1,043,119	194.04
194.05	07955	INDUSTRIAL MEDICINE	9,190	0	9,190	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)	8,718,834	0	8,718,834	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0084

Period:
From 12/01/2019
To 11/30/2020

Worksheet B-1

Date/Time Prepared:
6/30/2021 2:19 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	51,193,695			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	40,918	40,918	5,192,495	-28,690,779	95,901,283	5.00
7.00	00700	OPERATION OF PLANT	137,214	137,214	1,145,666	0	7,570,466	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,395	8,395	1,493	0	717,437	8.00
9.00	00900	HOUSEKEEPING	4,591	4,591	0	0	2,534,406	9.00
10.00	01000	DIETARY	14,861	14,861	0	0	3,719,218	10.00
13.00	01300	NURSING ADMINISTRATION	2,520	2,520	3,876,263	0	4,671,983	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,428	11,428	371,353	0	1,116,951	14.00
15.00	01500	PHARMACY	3,361	3,361	2,169,769	0	2,972,361	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,339	5,339	0	0	147,824	16.00
17.00	01700	SOCIAL SERVICE	438	438	0	0	7,838	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	76,951	76,951	10,831,845	0	14,781,833	30.00
31.00	03100	INTENSIVE CARE UNIT	13,763	13,763	3,010,417	0	5,037,014	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	1,065,597	0	1,535,976	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	26,968	26,968	1,922,452	0	4,670,620	50.00
51.00	05100	RECOVERY ROOM	3,302	3,302	1,284,977	0	1,588,769	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,544	8,544	1,599,984	0	2,398,980	52.00
53.00	05300	ANESTHESIOLOGY	901	901	41,741	0	282,065	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,383	25,383	3,802,846	0	7,161,957	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	3,616,564	0	7,454,322	60.00
65.00	06500	RESPIRATORY THERAPY	3,617	3,617	1,024,359	0	1,735,636	65.00
66.00	06600	PHYSICAL THERAPY	10,743	10,743	1,880,752	0	2,594,623	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	2,089,999	0	3,008,962	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	2,792,190	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,164,639	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,912,663	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	1,030,699	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03030	SLEEP LAB	726	726	217,183	0	320,119	76.01
76.02	03951	PSYCH SERVICES	0	0	127,813	0	226,948	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	51,459	0	73,048	90.00
91.00	09100	EMERGENCY	21,652	21,652	5,091,274	0	7,347,889	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	207,080	0	434,818	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	50,623,381	-28,690,779	94,012,254	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	244	244	0	0	4,366	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	30,944	192.00
194.00	07950	CLINIC CORPORATION	0	0	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	203	203	0	0	31,044	194.01
194.02	07952	MARKETING	0	0	84,299	0	313,031	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	694,786	194.04
194.05	07955	INDUSTRIAL MEDICINE	0	0	486,015	0	814,858	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)	5,966,847	2,751,987	5,193,490		28,690,779	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.246896	5.648427	0.101448		0.299170	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0084

Period:
From 12/01/2019
To 11/30/2020

Worksheet B-1

Date/Time Prepared:
6/30/2021 2:19 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)			134,036		745,834	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002618		0.007777	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 12/01/2019
To 11/30/2020

Worksheet B-1

Date/Time Prepared:
6/30/2021 2:19 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	753,539				8.00
9.00	00900	HOUSEKEEPING	4,591	0	288,605			9.00
10.00	01000	DIETARY	14,861	0	14,861	91,964		10.00
13.00	01300	NURSING ADMINISTRATION	2,520	0	2,520	0	25,193,282	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,428	20,742	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	307,022	76,951	79,231	10,831,845	30.00
31.00	03100	INTENSIVE CARE UNIT	13,763	63,679	13,763	12,733	3,010,417	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	7,900	2,515	0	1,065,597	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	26,968	68,804	26,968	0	1,922,452	50.00
51.00	05100	RECOVERY ROOM	3,302	30,072	3,302	0	1,284,977	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,544	67,452	8,544	0	1,599,984	52.00
53.00	05300	ANESTHESIOLOGY	901	0	901	0	41,741	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,383	56,280	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	1,956	3,617	0	0	65.00
66.00	06600	PHYSICAL THERAPY	10,743	169	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	13,819	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	217,183	76.01
76.02	03951	PSYCH SERVICES	0	0	0	0	127,813	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	115,644	21,652	0	5,091,273	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	753,539	249,333	91,964	25,193,282	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)	9,835,322	1,205,846	3,442,343	5,493,790	6,181,938	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	32.611457	1.600244	11.927524	59.738485	0.245380	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,517,367	225,889	140,188	426,129	113,836	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0084

Period:
From 12/01/2019
To 11/30/2020

Worksheet B-1

Date/Time Prepared:
6/30/2021 2:19 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)	8.346957	0.299771	0.485743	4.633650	0.004519	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 12/01/2019
To 11/30/2020

Worksheet B-1

Date/Time Prepared:
6/30/2021 2:19 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	10,244,471				14.00
15.00	01500	PHARMACY	171,446	3,912,663			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,710	0	1,065,767,906		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	36,731	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	650,110	0	117,303,268	28,903	30.00
31.00	03100	INTENSIVE CARE UNIT	512,125	0	26,039,057	4,645	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	72,924	0	6,743,062	3,183	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,047,813	0	161,698,815	0	50.00
51.00	05100	RECOVERY ROOM	17,476	0	15,975,703	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	238,553	0	10,124,645	0	52.00
53.00	05300	ANESTHESIOLOGY	185,316	0	5,482,026	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	260,193	0	199,698,848	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	975,543	0	118,941,758	0	60.00
65.00	06500	RESPIRATORY THERAPY	252,242	0	18,597,232	0	65.00
66.00	06600	PHYSICAL THERAPY	12,414	0	21,821,999	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	212,863	0	51,868,072	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,618,750	0	8,140,100	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,222,416	0	24,656,358	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,912,663	126,955,390	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	6,246,310	0	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	76.00
76.01	03030	SLEEP LAB	11,967	0	3,968,059	0	76.01
76.02	03951	PSYCH SERVICES	0	0	530,375	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	4,574	0	676,043	0	90.00
91.00	09100	EMERGENCY	673,777	0	140,300,786	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	48,843	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)	10,194,055	3,912,663	1,065,767,906	36,731	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	0	0	0	0	192.00
194.00	07950	CLINIC CORPORATION	0	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	0	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	50,416	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)	1,993,293	4,044,656	430,759	29,691	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.194573	1.033735	0.000404	0.808336	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	321,325	124,007	143,998	11,768	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0084

Period:
From 12/01/2019
To 11/30/2020

Worksheet B-1

Date/Time Prepared:
6/30/2021 2:19 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)	0.031366	0.031694	0.000135	0.320383		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 12/01/2019
To 11/30/2020Worksheet C
Part I
Date/Time Prepared:
6/30/2021 2:19 pm

			Title XVIII		Hospital		PPS	
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	30,711,055		30,711,055	0	30,711,055	30.00
31.00	03100	INTENSIVE CARE UNIT	8,872,096		8,872,096	0	8,872,096	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	2,401,114		2,401,114	0	2,401,114	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,120,092		8,120,092	0	8,120,092	50.00
51.00	05100	RECOVERY ROOM	2,584,434		2,584,434	0	2,584,434	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,048,274		4,048,274	0	4,048,274	52.00
53.00	05300	ANESTHESIOLOGY	455,094		455,094	0	455,094	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,656,689		10,656,689	0	10,656,689	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	10,402,695		10,402,695	0	10,402,695	60.00
65.00	06500	RESPIRATORY THERAPY	2,475,706	0	2,475,706	0	2,475,706	65.00
66.00	06600	PHYSICAL THERAPY	3,860,839	0	3,860,839	0	3,860,839	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,240,162		4,240,162	0	4,240,162	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,140,353		4,140,353	0	4,140,353	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,254,617		3,254,617	0	3,254,617	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,179,160		9,179,160	0	9,179,160	73.00
74.00	07400	RENAL DIALYSIS	1,341,577		1,341,577	0	1,341,577	74.00
76.00	03020	CARDIAC REHAB	0		0	0	0	76.00
76.01	03030	SLEEP LAB	505,447		505,447	0	505,447	76.01
76.02	03951	PSYCH SERVICES	326,421		326,421	0	326,421	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	96,065		96,065	0	96,065	90.00
91.00	09100	EMERGENCY	12,132,652		12,132,652	0	12,132,652	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,027,086		4,027,086	0	4,027,086	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	574,407		574,407	0	574,407	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)	124,406,035	0	124,406,035	0	124,406,035	200.00
201.00		Less Observation Beds	4,027,086		4,027,086		4,027,086	201.00
202.00		Total (see instructions)	120,378,949	0	120,378,949	0	120,378,949	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0084

Period:
From 12/01/2019
To 11/30/2020Worksheet C
Part I
Date/Time Prepared:
6/30/2021 2:19 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	101,636,785		101,636,785		30.00
31.00	03100	INTENSIVE CARE UNIT	26,039,057		26,039,057		31.00
40.00	04000	SUBPROVIDER - IPF	0		0		40.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
43.00	04300	NURSERY	6,743,062		6,743,062		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	82,910,381	78,788,434	161,698,815	0.050217	0.000000
51.00	05100	RECOVERY ROOM	6,884,760	9,090,943	15,975,703	0.161773	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,075,149	49,496	10,124,645	0.399844	0.000000
53.00	05300	ANESTHESIOLOGY	3,305,458	2,176,568	5,482,026	0.083016	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	57,544,013	142,154,835	199,698,848	0.053364	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	67,376,806	51,564,952	118,941,758	0.087460	0.000000
65.00	06500	RESPIRATORY THERAPY	16,853,417	1,743,815	18,597,232	0.133122	0.000000
66.00	06600	PHYSICAL THERAPY	12,407,551	9,414,448	21,821,999	0.176924	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	32,843,937	19,024,135	51,868,072	0.081749	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,660,025	3,480,075	8,140,100	0.508637	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,829,998	10,826,360	24,656,358	0.131999	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	101,586,892	25,368,498	126,955,390	0.072302	0.000000
74.00	07400	RENAL DIALYSIS	6,004,782	241,528	6,246,310	0.214779	0.000000
76.00	03020	CARDIAC REHAB	0	0	0	0.000000	0.000000
76.01	03030	SLEEP LAB	8,909	3,959,150	3,968,059	0.127379	0.000000
76.02	03951	PSYCH SERVICES	43,021	487,354	530,375	0.615453	0.000000
76.03	03952	WOUND CARE	0	0	0	0.000000	0.000000
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	299,146	376,897	676,043	0.142099	0.000000
91.00	09100	EMERGENCY	33,909,306	106,391,480	140,300,786	0.086476	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5,551,676	10,114,807	15,666,483	0.257051	0.000000
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0		116.00
200.00		Subtotal (see instructions)	590,514,131	475,253,775	1,065,767,906		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	590,514,131	475,253,775	1,065,767,906		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-0084	Period: From 12/01/2019 To 11/30/2020	Worksheet C Part I Date/Time Prepared: 6/30/2021 2:19 pm
				Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio			
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.050217			50.00
51.00	05100	RECOVERY ROOM	0.161773			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.399844			52.00
53.00	05300	ANESTHESIOLOGY	0.083016			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.053364			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	0.087460			60.00
65.00	06500	RESPIRATORY THERAPY	0.133122			65.00
66.00	06600	PHYSICAL THERAPY	0.176924			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.081749			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.508637			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.131999			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.072302			73.00
74.00	07400	RENAL DIALYSIS	0.214779			74.00
76.00	03020	CARDIAC REHAB	0.000000			76.00
76.01	03030	SLEEP LAB	0.127379			76.01
76.02	03951	PSYCH SERVICES	0.615453			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	0.142099			90.00
91.00	09100	EMERGENCY	0.086476			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.257051			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 12/01/2019
To 11/30/2020Worksheet C
Part I
Date/Time Prepared:
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			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	30,711,055		30,711,055	0	30,711,055	30.00
31.00	03100	INTENSIVE CARE UNIT	8,872,096		8,872,096	0	8,872,096	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	2,401,114		2,401,114	0	2,401,114	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,120,092		8,120,092	0	8,120,092	50.00
51.00	05100	RECOVERY ROOM	2,584,434		2,584,434	0	2,584,434	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,048,274		4,048,274	0	4,048,274	52.00
53.00	05300	ANESTHESIOLOGY	455,094		455,094	0	455,094	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,656,689		10,656,689	0	10,656,689	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	10,402,695		10,402,695	0	10,402,695	60.00
65.00	06500	RESPIRATORY THERAPY	2,475,706	0	2,475,706	0	2,475,706	65.00
66.00	06600	PHYSICAL THERAPY	3,860,839	0	3,860,839	0	3,860,839	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,240,162		4,240,162	0	4,240,162	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,140,353		4,140,353	0	4,140,353	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,254,617		3,254,617	0	3,254,617	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,179,160		9,179,160	0	9,179,160	73.00
74.00	07400	RENAL DIALYSIS	1,341,577		1,341,577	0	1,341,577	74.00
76.00	03020	CARDIAC REHAB	0		0	0	0	76.00
76.01	03030	SLEEP LAB	505,447		505,447	0	505,447	76.01
76.02	03951	PSYCH SERVICES	326,421		326,421	0	326,421	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	96,065		96,065	0	96,065	90.00
91.00	09100	EMERGENCY	12,132,652		12,132,652	0	12,132,652	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,027,086		4,027,086	0	4,027,086	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	574,407		574,407	0	574,407	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)	124,406,035	0	124,406,035	0	124,406,035	200.00
201.00		Less Observation Beds	4,027,086		4,027,086	0	4,027,086	201.00
202.00		Total (see instructions)	120,378,949	0	120,378,949	0	120,378,949	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0084

Period:
From 12/01/2019
To 11/30/2020Worksheet C
Part I
Date/Time Prepared:
6/30/2021 2:19 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		
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	101,636,785		101,636,785		30.00
31.00	03100	INTENSIVE CARE UNIT	26,039,057		26,039,057		31.00
40.00	04000	SUBPROVIDER - IPF	0		0		40.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
43.00	04300	NURSERY	6,743,062		6,743,062		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	82,910,381	78,788,434	161,698,815	0.050217	0.000000
51.00	05100	RECOVERY ROOM	6,884,760	9,090,943	15,975,703	0.161773	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,075,149	49,496	10,124,645	0.399844	0.000000
53.00	05300	ANESTHESIOLOGY	3,305,458	2,176,568	5,482,026	0.083016	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	57,544,013	142,154,835	199,698,848	0.053364	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	67,376,806	51,564,952	118,941,758	0.087460	0.000000
65.00	06500	RESPIRATORY THERAPY	16,853,417	1,743,815	18,597,232	0.133122	0.000000
66.00	06600	PHYSICAL THERAPY	12,407,551	9,414,448	21,821,999	0.176924	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	32,843,937	19,024,135	51,868,072	0.081749	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,660,025	3,480,075	8,140,100	0.508637	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,829,998	10,826,360	24,656,358	0.131999	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	101,586,892	25,368,498	126,955,390	0.072302	0.000000
74.00	07400	RENAL DIALYSIS	6,004,782	241,528	6,246,310	0.214779	0.000000
76.00	03020	CARDIAC REHAB	0	0	0	0.000000	0.000000
76.01	03030	SLEEP LAB	8,909	3,959,150	3,968,059	0.127379	0.000000
76.02	03951	PSYCH SERVICES	43,021	487,354	530,375	0.615453	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	299,146	376,897	676,043	0.142099	0.000000
91.00	09100	EMERGENCY	33,909,306	106,391,480	140,300,786	0.086476	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5,551,676	10,114,807	15,666,483	0.257051	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)	590,514,131	475,253,775	1,065,767,906		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	590,514,131	475,253,775	1,065,767,906		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0084

Period:
From 12/01/2019
To 11/30/2020Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	05401	ULTRASOUND	0.000000			54.01
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
76.00	03020	CARDIAC REHAB	0.000000			76.00
76.01	03030	SLEEP LAB	0.000000			76.01
76.02	03951	PSYCH SERVICES	0.000000			76.02
76.03	03952	WOUND CARE	0.000000			76.03
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE				116.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0084

Period:
From 12/01/2019
To 11/30/2020Worksheet D
Part I
Date/Time Prepared:
6/30/2021 2:19 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	2,753,669	0	2,753,669	33,265	82.78	30.00
31.00	INTENSIVE CARE UNIT	527,670		527,670	4,645	113.60	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	93,357		93,357	3,183	29.33	43.00
200.00	Total (lines 30 through 199)	3,374,696		3,374,696	41,093		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	10,130	838,561				
31.00	INTENSIVE CARE UNIT	1,578	179,261				
40.00	SUBPROVIDER - IPF	0	0				
41.00	SUBPROVIDER - IRF	0	0				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	11,708	1,017,822				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0084

Period:
From 12/01/2019
To 11/30/2020Worksheet D
Part II
Date/Time Prepared:
6/30/2021 2:19 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	846,166	161,698,815	0.005233	23,780,898	124,445	50.00
51.00	05100	RECOVERY ROOM	121,503	15,975,703	0.007605	1,221,636	9,291	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	287,508	10,124,645	0.028397	21,794	619	52.00
53.00	05300	ANESTHESIOLOGY	33,127	5,482,026	0.006043	555,394	3,356	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	796,203	199,698,848	0.003987	22,231,452	88,637	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	402,384	118,941,758	0.003383	23,087,504	78,105	60.00
65.00	06500	RESPIRATORY THERAPY	123,864	18,597,232	0.006660	6,960,552	46,357	65.00
66.00	06600	PHYSICAL THERAPY	315,626	21,821,999	0.014464	5,784,156	83,662	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	194,635	51,868,072	0.003753	11,765,359	44,155	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	104,952	8,140,100	0.012893	1,280,541	16,510	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	89,871	24,656,358	0.003645	4,831,020	17,609	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	171,575	126,955,390	0.001351	32,166,531	43,457	73.00
74.00	07400	RENAL DIALYSIS	8,859	6,246,310	0.001418	2,650,801	3,759	74.00
76.00	03020	CARDIAC REHAB	0	0	0.000000	0	0	76.00
76.01	03030	SLEEP LAB	24,356	3,968,059	0.006138	8,907	55	76.01
76.02	03951	PSYCH SERVICES	2,750	530,375	0.005185	6,485	34	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	937	676,043	0.001386	0	0	90.00
91.00	09100	EMERGENCY	746,938	140,300,786	0.005324	11,871,592	63,204	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	361,085	15,666,483	0.023048	1,784,170	41,122	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	4,632,339	931,349,002		150,008,792	664,377	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0084		Period: From 12/01/2019 To 11/30/2020		Worksheet D Part III Date/Time Prepared: 6/30/2021 2:19 pm		
					Title XVIII		Hospital		PPS		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost				
			1A	1.00	2A	2.00	3.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00		
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	41.00		
43.00	04300	NURSERY	0	0	0	0	0	0	43.00		
200.00	Total (lines 30 through 199)		0	0	0	0	0	0	200.00		
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)		Inpatient Program Days			
			4.00	5.00	6.00	7.00		8.00			
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	33,265	0.00	10,130		30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	4,645	0.00	1,578		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	3,183	0.00	0		43.00		
200.00	Total (lines 30 through 199)		0	0	41,093		11,708		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 12/01/2019
To 11/30/2020Worksheet D
Part IV
Date/Time Prepared:
6/30/2021 2:19 pm

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0084		Period: From 12/01/2019 To 11/30/2020		Worksheet D Part IV Date/Time Prepared: 6/30/2021 2:19 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) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	161,698,815	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	15,975,703	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	10,124,645	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	5,482,026	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	199,698,848	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	118,941,758	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	18,597,232	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	21,821,999	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	51,868,072	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	8,140,100	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	24,656,358	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	126,955,390	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	6,246,310	0.000000	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0.000000	76.00
76.01	03030	SLEEP LAB	0	0	0	3,968,059	0.000000	76.01
76.02	03951	PSYCH SERVICES	0	0	0	530,375	0.000000	76.02
76.03	03952	WOUND CARE	0	0	0	0	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
90.00	09000	CLINIC	0	0	0	676,043	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	140,300,786	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	15,666,483	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	931,349,002		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0084

Period:
From 12/01/2019
To 11/30/2020Worksheet D
Part IV
Date/Time Prepared:
6/30/2021 2:19 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	23,780,898	0	16,817,000	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	1,221,636	0	1,539,294	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	21,794	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	555,394	0	369,357	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	22,231,452	0	25,066,332	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	23,087,504	0	4,897,368	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	6,960,552	0	373,355	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	5,784,156	0	106,673	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	11,765,359	0	4,336,554	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,280,541	0	827,981	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	4,831,020	0	3,046,926	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	32,166,531	0	4,845,090	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	2,650,801	0	99,633	0	74.00
76.00	03020	CARDIAC REHAB	0.000000	0	0	0	0	76.00
76.01	03030	SLEEP LAB	0.000000	8,907	0	1,162,236	0	76.01
76.02	03951	PSYCH SERVICES	0.000000	6,485	0	2,766	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	69,890	0	90.00
91.00	09100	EMERGENCY	0.000000	11,871,592	0	10,141,913	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,784,170	0	1,257,568	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		150,008,792	0	74,959,936	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0084		Period: From 12/01/2019 To 11/30/2020		Worksheet D Part V Date/Time Prepared: 6/30/2021 2:19 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	0.050217	16,817,000	0	0	844,499	50.00	
51.00	05100	RECOVERY ROOM	0.161773	1,539,294	0	0	249,016	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.399844	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.083016	369,357	0	0	30,663	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.053364	25,066,332	0	0	1,337,640	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	0.087460	4,897,368	0	0	428,324	60.00	
65.00	06500	RESPIRATORY THERAPY	0.133122	373,355	0	0	49,702	65.00	
66.00	06600	PHYSICAL THERAPY	0.176924	106,673	0	0	18,873	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	0.081749	4,336,554	0	0	354,509	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.508637	827,981	0	0	421,142	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.131999	3,046,926	0	0	402,191	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.072302	4,845,090	0	16,837	350,310	73.00	
74.00	07400	RENAL DIALYSIS	0.214779	99,633	0	0	21,399	74.00	
76.00	03020	CARDIAC REHAB	0.000000	0	0	0	0	76.00	
76.01	03030	SLEEP LAB	0.127379	1,162,236	0	0	148,044	76.01	
76.02	03951	PSYCH SERVICES	0.615453	2,766	0	0	1,702	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						88.00	
90.00	09000	CLINIC	0.142099	69,890	0	0	9,931	90.00	
91.00	09100	EMERGENCY	0.086476	10,141,913	0	0	877,032	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.257051	1,257,568	0	0	323,259	92.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00	
200.00		Subtotal (see instructions)		74,959,936	0	16,837	5,868,236	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00	
202.00		Net Charges (line 200 - line 201)		74,959,936	0	16,837	5,868,236	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0084

Period:
From 12/01/2019
To 11/30/2020Worksheet D
Part V
Date/Time Prepared:
6/30/2021 2:19 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	1,217		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				88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	1,217		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,217		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0084	Period: From 12/01/2019 To 11/30/2020	Worksheet D-1 Date/Time Prepared: 6/30/2021 2:19 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)		33,265	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		33,265	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)		28,903	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) (see instructions)		10,130	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)		30,711,055	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)		30,711,055	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)		30,711,055	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)		923.22	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		9,352,219	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)		9,352,219	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0084

Period:
From 12/01/2019
To 11/30/2020

Worksheet D-1

Date/Time Prepared:
6/30/2021 2:19 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	8,872,096	4,645	1,910.03	1,578	3,014,027
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)					13,238,430
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					25,604,676
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,017,822
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					664,377
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,682,199
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					23,922,477
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)					4,362
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					923.22
89.00	Observation bed cost (line 87 x line 88) (see instructions)					4,027,086

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0084

Period:
From 12/01/2019
To 11/30/2020

Worksheet D-1

Date/Time Prepared:
6/30/2021 2:19 pm

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	2,753,669	30,711,055	0.089664	4,027,086	361,085	90.00
91.00 Nursing School cost	0	30,711,055	0.000000	4,027,086	0	91.00
92.00 Allied health cost	0	30,711,055	0.000000	4,027,086	0	92.00
93.00 All other Medical Education	0	30,711,055	0.000000	4,027,086	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0084	Period: From 12/01/2019 To 11/30/2020	Worksheet D-3 Date/Time Prepared: 6/30/2021 2:19 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		36,630,992	30.00
31.00	03100	INTENSIVE CARE UNIT		8,832,552	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	0.050217	23,780,898	1,194,205 50.00
51.00	05100	RECOVERY ROOM	0.161773	1,221,636	197,628 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.399844	21,794	8,714 52.00
53.00	05300	ANESTHESIOLOGY	0.083016	555,394	46,107 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.053364	22,231,452	1,186,359 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	0.087460	23,087,504	2,019,233 60.00
65.00	06500	RESPIRATORY THERAPY	0.133122	6,960,552	926,603 65.00
66.00	06600	PHYSICAL THERAPY	0.176924	5,784,156	1,023,356 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	0.081749	11,765,359	961,806 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.508637	1,280,541	651,331 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.131999	4,831,020	637,690 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.072302	32,166,531	2,325,705 73.00
74.00	07400	RENAL DIALYSIS	0.214779	2,650,801	569,336 74.00
76.00	03020	CARDIAC REHAB	0.000000	0	0 76.00
76.01	03030	SLEEP LAB	0.127379	8,907	1,135 76.01
76.02	03951	PSYCH SERVICES	0.615453	6,485	3,991 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	0.142099	0	0 90.00
91.00	09100	EMERGENCY	0.086476	11,871,592	1,026,608 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.257051	1,784,170	458,623 92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		150,008,792	13,238,430 200.00
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)		150,008,792	13,238,430 202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0084	Period: From 12/01/2019 To 11/30/2020	Worksheet E Part A Date/Time Prepared: 6/30/2021 2:19 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)		18,180,482	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		3,607,383	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)		85,938	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		17,888	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)		178.08	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)		42.46	31.00
32.00	Sum of lines 30 and 31		49.97	32.00
33.00	Allowable disproportionate share percentage (see instructions)		21.46	33.00
34.00	Disproportionate share adjustment (see instructions)		1,168,919	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0084	Period: From 12/01/2019 To 11/30/2020	Worksheet E Part A Date/Time Prepared: 6/30/2021 2:19 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)	2,131,739	1,216,785		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,776,448	203,353		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,979,801			36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges, excluding 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)	25,040,411			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)		25,040,411		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,883,263		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		35,807		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)		26,959,481		59.00
60.00	Primary payer payments		24,131		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		26,935,350		61.00
62.00	Deductibles billed to program beneficiaries		2,104,828		62.00
63.00	Coinsurance billed to program beneficiaries		196,746		63.00
64.00	Allowable bad debts (see instructions)		1,292,759		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		840,293		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		654,326		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		25,474,069		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)		-7,725		70.93
70.94	HRR adjustment amount (see instructions)		-238,642		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0084	Period: From 12/01/2019 To 11/30/2020	Worksheet E Part A Date/Time Prepared: 6/30/2021 2:19 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)		25,227,702	71.00	
71.01	Sequestration adjustment (see instructions)		209,390	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		24,138,101	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)		880,211	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		4,135,680	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	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00
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 12/01/2019 To 11/30/2020	Worksheet E Part B Date/Time Prepared: 6/30/2021 2:19 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		1,217	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		5,868,236	2.00
3.00	OPPS payments		5,905,268	3.00
4.00	Outlier payment (see instructions)		9,445	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)		1,217	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		16,837	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)		16,837	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)		16,837	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		15,620	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)		1,217	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)		5,914,713	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		72,784	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		999,121	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)		4,844,025	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)		4,844,025	30.00
31.00	Primary payer payments		2,132	31.00
32.00	Subtotal (line 30 minus line 31)		4,841,893	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)		557,392	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		362,305	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		202,320	36.00
37.00	Subtotal (see instructions)		5,204,198	37.00
38.00	MSP-LCC reconciliation amount from PS&R		369	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)		5,203,829	40.00
40.01	Sequestration adjustment (see instructions)		43,192	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		5,120,026	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)		40,611	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 12/01/2019
To 11/30/2020Worksheet E-1
Part I
Date/Time Prepared:
6/30/2021 2:19 pm

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		24,138,101		5,120,026	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		24,138,101		5,120,026	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		880,211		40,611	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		25,018,312		5,160,637	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 12/01/2019 To 11/30/2020	Worksheet E-1 Part II Date/Time Prepared: 6/30/2021 2:19 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 12/01/2019
To 11/30/2020

Worksheet G

Date/Time Prepared:
6/30/2021 2:19 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	-1,022,710	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	50,364,489	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-30,591,066	0	0	0	6.00
7.00	Inventory	3,807,191	0	0	0	7.00
8.00	Prepaid expenses	993,809	0	0	0	8.00
9.00	Other current assets	1,101,834	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)	24,653,547	0	0	0	11.00
FIXED ASSETS						
12.00	Land	6,861,624	0	0	0	12.00
13.00	Land improvements	422,822	0	0	0	13.00
14.00	Accumulated depreciation	-57,274	0	0	0	14.00
15.00	Buildings	28,809,149	0	0	0	15.00
16.00	Accumulated depreciation	-574,732	0	0	0	16.00
17.00	Leasehold improvements	433,250	0	0	0	17.00
18.00	Accumulated depreciation	-631,763	0	0	0	18.00
19.00	Fixed equipment	1,399,964	0	0	0	19.00
20.00	Accumulated depreciation	-124,458	0	0	0	20.00
21.00	Automobiles and trucks	25,767	0	0	0	21.00
22.00	Accumulated depreciation	-718	0	0	0	22.00
23.00	Major movable equipment	2,754,780	0	0	0	23.00
24.00	Accumulated depreciation	2,238,427	0	0	0	24.00
25.00	Minor equipment depreciable	644,207	0	0	0	25.00
26.00	Accumulated depreciation	368,850	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)	42,569,895	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	4,583,086	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,583,086	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	71,806,528	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	20,088,471	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,183,409	0	0	0	38.00
39.00	Payroll taxes payable	1,854,114	0	0	0	39.00
40.00	Notes and loans payable (short term)	308,955	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	23,375,493	0	0	0	43.00
44.00	Other current liabilities	8,076,911	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	58,887,353	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	473,081	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	473,081	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	59,360,434	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	12,446,094	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	12,446,094	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	71,806,528	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0084

Period:
From 12/01/2019
To 11/30/2020

Worksheet G-1

Date/Time Prepared:
6/30/2021 2:19 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		106,185,922		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		11,801,667				2.00
3.00	Total (sum of line 1 and line 2)		117,987,589		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)		117,987,589		0		11.00
12.00	REORGANIZATION ADJUSTMENTS TO RE	105,541,495		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)		105,541,495		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		12,446,094		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	REORGANIZATION ADJUSTMENTS TO RE		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 12/01/2019
To 11/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
6/30/2021 2:19 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	108,379,847		108,379,847	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)	108,379,847		108,379,847	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	26,039,057		26,039,057	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	26,039,057		26,039,057	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	134,418,904		134,418,904	17.00
18.00	Ancillary services	416,332,458	358,373,232	774,705,690	18.00
19.00	Outpatient services	39,760,128	116,883,184	156,643,312	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	1,014,319	1,014,319	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	590,511,490	476,270,735	1,066,782,225	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		149,880,417		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)		149,880,417		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0084

Period:
From 12/01/2019
To 11/30/2020

Worksheet G-3

Date/Time Prepared:
6/30/2021 2:19 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,066,782,225	1.00
2.00	Less contractual allowances and discounts on patients' accounts	922,673,051	2.00
3.00	Net patient revenues (line 1 minus line 2)	144,109,174	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	149,880,417	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-5,771,243	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	17,572,910	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	17,572,910	25.00
26.00	Total (line 5 plus line 25)	11,801,667	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)	11,801,667	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0084	Period: From 12/01/2019 To 11/30/2020	Worksheet L Parts I-III Date/Time Prepared: 6/30/2021 2:19 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,686,973	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		16,627	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)		91.80	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)		42.46	8.00
9.00	Sum of lines 7 and 8		49.97	9.00
10.00	Allowable disproportionate share percentage (see instructions)		10.65	10.00
11.00	Disproportionate share adjustment (see instructions)		179,663	11.00
12.00	Total prospective capital payments (see instructions)		1,883,263	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