

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: 14-0124	Period: From 12/01/2018 To 11/30/2019	Worksheet S Parts I-III Date/Time Prepared: 6/26/2020 4:52 pm
--	-----------------------	---	--

PART I - COST REPORT STATUS

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by JOHN H. STROGER JR. HOSP OF COOK CTY (14-0124) for the cost reporting period beginning 12/01/2018 and ending 11/30/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
	PART III - SETTLEMENT SUMMARY	1.00	2.00	3.00	4.00	5.00	
1.00	Hospital	0	14,472,580	-400,279	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
200.00	Total	0	14,472,580	-400,279	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: 14-0124		Period: From 12/01/2018 To 11/30/2019		Worksheet S-2 Part I Date/Time Prepared: 6/26/2020 4:52 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 1901 WEST HARRISON STREET			PO Box:				1.00	
2.00	City: CHICAGO			State: IL		Zip Code: 60612-3714		County: COOK	
		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			JOHN H. STROGER JR. HOSP OF COOK CTY	140124	16974	1	07/01/1966	N P O
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis			JOHN H. STROGER JR. HOSP DIALYSIS	142313	16794		07/01/1973	
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						12/01/2018	11/30/2019	20.00
21.00	Type of Control (see instructions)						9		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N		23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
				1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			13,733	0	0	0	22,437	0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet S-2
Part I
Date/Time Prepared:
6/26/2020 4:52 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
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals								
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					Y		
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.					N		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		
					NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
					1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)				Y			60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)					23.00	1	60.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet S-2
Part I
Date/Time Prepared:
6/26/2020 4:52 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)	N			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			
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet S-2
Part I
Date/Time Prepared:
6/26/2020 4:52 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	3.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
			1.00	2.00	3.00	
			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

6/26/2020 4:52 pm Y:\15601 - John H Stroger Jr. Hospital of Cook County\300 - Medicare Cost Report\20191130\HFS Files\2019 Stoger

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0124	Period: From 12/01/2018 To 11/30/2019	Worksheet S-2 Part I Date/Time Prepared: 6/26/2020 4:52 pm
			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	Y	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.	N	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.	N	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.	N	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.	N	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.	N	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)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			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
		1.00	2.00	3.00
				Respiratory
				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.			109.00
			1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N		110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0124	Period: From 12/01/2018 To 11/30/2019	Worksheet S-2 Part I Date/Time Prepared: 6/26/2020 4:52 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
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1,624,757	19,585,000		0 118.01
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		HB2320	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet S-2
Part I
Date/Time Prepared:
6/26/2020 4:52 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: COOK COUNTY	Contractor's Name: COOK COUNTY		Contractor's Number: 00131		141.00	
142.00	Street: 1340 S. DAMEN AVENUE	PO Box: SUITE 215				142.00	
143.00	City: CHICAGO	State: IL		Zip Code: 60608		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?					Y	144.00
						1.00	
						2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				N	Y	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N		146.00
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N	149.00
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
						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	Ending
						1.00	2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)						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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0124		Period: From 12/01/2018 To 11/30/2019		Worksheet S-2 Part II Date/Time Prepared: 6/26/2020 4:52 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.			Y	A		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.			Y			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.			Y			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.			Y			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.			Y			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	05/21/2020	Y	05/21/2020
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet S-2
Part II
Date/Time Prepared:
6/26/2020 4:52 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				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.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				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.				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				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				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.				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.				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.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				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.				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.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				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.	MICHAEL	SUMRALL		41.00
42.00	Enter the employer/company name of the cost report preparer.	COOK COUNTY HEALTH & HOSPITAL SYSTEM			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	312-864-4776	MSUMRALL@COOKCOUNTYHHS.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet S-2
Part II
Date/Time Prepared:
6/26/2020 4:52 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.	COST & 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

DRAFT

		Title V	Title XIX	
		1.00	2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)	N	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.01)	N	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.02)	N	Y	3.00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?	N	N	3.01
		Inpatient	Outpatient	
		1.00	2.00	
CRITICAL ACCESS HOSPITALS				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
RCE DISALLOWANCE				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.05)	N	Y	6.00
PASS THROUGH COST				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.06)	N	Y	7.00
RHC				
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	8.00
FQHC				
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	9.00
		State		
		1.00		
STATE MEDICAID FORMS				
10.00	Select the state when using state Medicaid forms.			10.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet S-3
Part I
Date/Time Prepared:
6/26/2020 4:52 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	320	116,800	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)		320	116,800	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	32	11,680	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT	33.00	8	2,920	0.00	0	10.00
11.00 SURGICAL INTENSIVE CARE UNIT	34.00	14	5,110	0.00	0	11.00
11.01 PEDIATRIC INTENSIVE CARE UNIT	34.01	0	0	0.00	0	11.01
11.02 TRAUMA INTENSIVE CARE UNIT	34.02	12	4,380	0.00	0	11.02
11.03 NEURO INTENSIVE CARE	34.03	10	3,650	0.00	0	11.03
11.04 NEONATAL INTENSIVE CARE UNIT	34.04	52	18,980	0.00	0	11.04
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		448	163,520	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		448				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)		9	3,285			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: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet S-3
Part I
Date/Time Prepared:
6/26/2020 4:52 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)	7,649	9,045	63,089			1.00
2.00	HMO and other (see instructions)	3,769	22,437				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)	7,649	9,045	63,089			7.00
8.00	INTENSIVE CARE UNIT	1,092	1,390	8,255			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT	172	114	1,328			10.00
11.00	SURGICAL INTENSIVE CARE UNIT	312	307	2,838			11.00
11.01	PEDIATRIC INTENSIVE CARE UNIT	0	0	0			11.01
11.02	TRAUMA INTENSIVE CARE UNIT	245	356	2,175			11.02
11.03	NEURO INTENSIVE CARE	165	235	1,842			11.03
11.04	NEONATAL INTENSIVE CARE UNIT	0	1,791	6,753			11.04
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		495	1,936			13.00
14.00	Total (see instructions)	9,635	13,733	88,216	477.24	5,070.12	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				477.24	5,070.12	27.00
28.00	Observation Bed Days		0	20,907			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	1,051			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: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet S-3
Part I
Date/Time Prepared:
6/26/2020 4:52 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	1,674	3,371	16,237	1.00
2.00 HMO and other (see instructions)			603	2,226		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
11.01 PEDIATRIC INTENSIVE CARE UNIT						11.01
11.02 TRAUMA INTENSIVE CARE UNIT						11.02
11.03 NEURO INTENSIVE CARE						11.03
11.04 NEONATAL INTENSIVE CARE UNIT						11.04
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,674	3,371	16,237	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet S-3
Part II
Date/Time Prepared:
6/26/2020 4:52 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	480,461,140	-3,161,621	477,299,519	10,545,859.00	45.26
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		1,934,946	0	1,934,946	22,461.00	86.15
4.00	Physician-Part A - Administrative		62,586,099	0	62,586,099	415,905.00	150.48
4.01	Physicians - Part A - Teaching		9,117,816	0	9,117,816	72,395.00	125.95
5.00	Physician and Non Physician-Part B		77,794,640	0	77,794,640	705,158.00	110.32
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	24,596,167	1,348,336	25,944,503	860,515.00	30.15
7.01	Contracted interns and residents (in an approved programs)		4,385,761	0	4,385,761	105,326.00	41.64
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)		0	894,791	894,791	17,497.00	51.14
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		17,241,192	0	17,241,192	296,083.00	58.23
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		40,601,546	0	40,601,546	933,031.00	43.52
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		87,229,300	0	87,229,300		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		258,489	0	258,489		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		553,217	0	553,217		
22.00	Physician Part A - Administrative		17,777,639	0	17,777,639		
22.01	Physician Part A - Teaching		2,594,341	0	2,594,341		
23.00	Physician Part B		22,168,064	0	22,168,064		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		7,627,408	0	7,627,408		
25.50	Home office wage-related (core)		8,874,742	0	8,874,742		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	2,116,743	0	2,116,743	40,874.00	51.79
27.00	Administrative & General	5.00	23,448,898	434,786	23,883,684	793,779.00	30.09

6/26/2020 4:52 pm Y:\15601 - John H Stroger Jr. Hospital of Cook County\300 - Medicare Cost Report\20191130\HFS Files\2019 Stoger

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet S-3
Part II
Date/Time Prepared:
6/26/2020 4:52 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		539,123	0	539,123	10,185.00	52.93	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	16,336,479	0	16,336,479	367,218.00	44.49	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	9,320,564	0	9,320,564	405,293.00	23.00	32.00
33.00	Housekeeping under contract (see instructions)		489,247	0	489,247	21,351.00	22.91	33.00
34.00	Dietary	10.00	4,135,893	-2,485,333	1,650,560	72,259.00	22.84	34.00
35.00	Dietary under contract (see instructions)		746,022	0	746,022	32,556.00	22.92	35.00
36.00	Cafeteria	11.00	0	2,485,333	2,485,333	108,804.00	22.84	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	5,983,322	0	5,983,322	100,164.00	59.74	38.00
39.00	Central Services and Supply	14.00	4,399,314	0	4,399,314	177,448.00	24.79	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	3,799,766	0	3,799,766	118,153.00	32.16	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

DRAFT

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet S-3
Part III
Date/Time Prepared:
6/26/2020 4:52 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)	364,406,202	-4,509,957	359,896,245	8,844,096.00	40.69	1.00
2.00	Excluded area salaries (see instructions)	0	894,791	894,791	17,497.00	51.14	2.00
3.00	Subtotal salaries (line 1 minus line 2)	364,406,202	-5,404,748	359,001,454	8,826,599.00	40.67	3.00
4.00	Subtotal other wages & related costs (see inst.)	57,842,738	0	57,842,738	1,229,114.00	47.06	4.00
5.00	Subtotal wage-related costs (see inst.)	113,881,681	0	113,881,681	0.00	31.72	5.00
6.00	Total (sum of lines 3 thru 5)	536,130,621	-5,404,748	530,725,873	10,055,713.00	52.78	6.00
7.00	Total overhead cost (see instructions)	71,315,371	434,786	71,750,157	2,248,084.00	31.92	7.00

DRAFT

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet S-3
Part IV
Date/Time Prepared:
6/26/2020 4:52 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	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)	53,846,568	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)	53,194,573	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	17,365,872	9.00
10.00	Dental, Hearing and Vision Plan	2,597,619	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	831,575	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	2,809,945	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	0	17.00
18.00	Medicare Taxes - Employers Portion Only	6,341,844	18.00
19.00	Unemployment Insurance	178,558	19.00
20.00	State or Federal Unemployment Taxes	0	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	1,041,904	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	138,208,458	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED - MALPRACTICE EXP		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet S-3
Part V
Date/Time Prepared:
6/26/2020 4:52 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	17,241,192	138,208,458	1.00
2.00	Hospital	17,241,192	87,229,300	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			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 OLTG			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	50,979,158	18.00

DRAFT

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

Provider CCN: 14-0124

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

Worksheet S-5

Date/Time Prepared:
6/26/2020 4:52 pm

		Outpatient		Training		Home			
		Regular	High Flux	Hemodialysis	CAPD / CCPD	Hemodialysis	CAPD / CCPD		
		1.00	2.00	3.00	4.00	5.00	6.00		
1.00	Number of patients in program at end of cost reporting period	29	0	0	0	0	0	1.00	
2.00	Number of times per week patient receives dialysis	3.50	0.00	0.00	0.00	0.00	0.00	2.00	
3.00	Average patient dialysis time including setup	5.00	0.00	0.00	0.00	0.00	0.00	3.00	
4.00	CAPD exchanges per day				0.00		0.00	4.00	
5.00	Number of days in year dialysis furnished	312	0					5.00	
6.00	Number of stations	8	0	0	0			6.00	
7.00	Treatment capacity per day per station	4	0					7.00	
8.00	Utilization (see instructions)	0.00	0.00					8.00	
9.00	Average times dialyzers re-used	0.00	0.00					9.00	
10.00	Percentage of patients re-using dialyzers	0.00	0.00					10.00	
								Y/N	
								1.00	
ESRD PPS									
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter "Y" for yes or "N" for no. (see instructions)							N	10.01
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter "Y" for yes or "N" for no. (See instructions for "new" providers.)							Y	10.02
						Prior to 1/1	After 12/31		
						1.00	2.00		
10.03	If you responded "N" to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)							0	10.03
TRANSPLANT INFORMATION									
11.00	Number of patients on transplant list							0	11.00
12.00	Number of patients transplanted during the cost reporting period							0	12.00
EPOETIN									
13.00	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider.								13.00
14.00	Epoetin amount from Worksheet A for Home Dialysis program								14.00
15.00	Number of EPO units furnished relating to the renal dialysis department								15.00
16.00	Number of EPO units furnished relating to the home dialysis department								16.00
ARANESP									
17.00	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider.								17.00
18.00	ARANESP amount from Worksheet A for Home Dialysis program								18.00
19.00	Number of ARANESP units furnished relating to the renal dialysis department								19.00
20.00	Number of ARANESP units furnished relating to the home dialysis department								20.00
						MCP	INITIAL METHOD		
						1.00	2.00		
PHYSICIAN PAYMENT METHOD									
21.00	Enter "X" if method(s) is applicable							X	21.00
		ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.			
		1.00	2.00	3.00	4.00	5.00			
ESAs									
22.00	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)							0	22.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

Provider CCN: 14-0124

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

Worksheet S-5

Date/Time Prepared:
6/26/2020 4:52 pm

		CCN	Treatments	
		1.00	2.00	
23.00	If line 10.01 is yes, enter in column 1 the CCN for each renal dialysis facility listed on Worksheet S-2, Part I, line 18, and its subscripts. Enter in column 2, the total treatments for each CCN. (see instructions)	142313	6,781	23.00

DRAFT

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0124

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

Worksheet S-10

Date/Time Prepared:
6/26/2020 4:52 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)			0.707866	1.00
	Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			79,611,451	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?			Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			351,775,034	6.00
7.00	Medicaid cost (line 1 times line 6)			249,009,586	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)			169,398,135	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP			2,416,549	9.00
10.00	Stand-alone CHIP charges			3,209,847	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			2,272,142	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)			2,710,355	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			4,892,929	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			3,463,538	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)			753,183	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)			170,151,318	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)	496,123,268	0	496,123,268	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	351,188,793	0	351,188,793	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	351,188,793	0	351,188,793	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			280,264,794	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			2,146,772	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			3,302,726	27.01
28.00	Non-Medicare bad debt expense (see instructions)			276,962,068	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			197,207,985	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			548,396,778	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			718,548,096	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0124

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

Worksheet A

Date/Time Prepared:
6/26/2020 4:52 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		17,498,390	17,498,390	327,314	17,825,704	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		6,555,630	6,555,630	0	6,555,630	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,116,743	84,066,882	86,183,625	3,245,062	89,428,687	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	23,448,898	154,962,775	178,411,673	-3,034,886	175,376,787	5.00
7.00	00700	OPERATION OF PLANT	16,336,479	25,782,364	42,118,843	0	42,118,843	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,359,876	1,359,876	0	1,359,876	8.00
9.00	00900	HOUSEKEEPING	9,320,564	1,366,413	10,686,977	489,247	11,176,224	9.00
10.00	01000	DIETARY	4,135,893	4,702,905	8,838,798	-5,903,345	2,935,453	10.00
11.00	01100	CAFETERIA	0	0	0	5,311,394	5,311,394	11.00
13.00	01300	NURSING ADMINISTRATION	5,983,322	4,796,020	10,779,342	0	10,779,342	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,399,314	33,758,052	38,157,366	-8,826,912	29,330,454	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,799,766	4,797,558	8,597,324	0	8,597,324	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	24,596,167	3,527,844	28,124,011	1,348,336	29,472,347	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	1,839,494	1,055,043	2,894,537	9,550,656	12,445,193	22.00
23.00	02300	ALLIED HEALTH	0	0	0	203,553	203,553	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	60,976,383	4,947,166	65,923,549	-2,104,487	63,819,062	30.00
31.00	03100	INTENSIVE CARE UNIT	8,305,489	4,253	8,309,742	299,281	8,609,023	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	4,957,050	9,573	4,966,623	10,092	4,976,715	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	4,276,797	0	4,276,797	25,407	4,302,204	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	6,690,763	281,966	6,972,729	331,192	7,303,921	34.02
34.03	02400	NEURO INTENSIVE CARE	2,573,851	955	2,574,806	45,490	2,620,296	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	6,786,954	103	6,787,057	3,366	6,790,423	34.04
43.00	04300	NURSERY	2,492,872	-7,054	2,485,818	0	2,485,818	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	42,482,002	15,150,732	57,632,734	-1,307,991	56,324,743	50.00
51.00	05100	RECOVERY ROOM	3,386,645	2,563	3,389,208	0	3,389,208	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,307,480	967	3,308,447	77,283	3,385,730	52.00
53.00	05300	ANESTHESIOLOGY	12,168,841	289,496	12,458,337	-979,306	11,479,031	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,559,906	9,067,145	29,627,051	-688,442	28,938,609	54.00
60.00	06000	LABORATORY	16,372,672	17,296,455	33,669,127	-1,046,851	32,622,276	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	994,040	2,795,274	3,789,314	0	3,789,314	62.00
65.00	06500	RESPIRATORY THERAPY	8,506,933	1,306,329	9,813,262	0	9,813,262	65.00
66.00	06600	PHYSICAL THERAPY	2,836,898	244,342	3,081,240	0	3,081,240	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,043,801	48,583	1,092,384	0	1,092,384	67.00
68.00	06800	SPEECH PATHOLOGY	480,704	131,777	612,481	0	612,481	68.00
69.00	06900	ELECTROCARDIOLOGY	7,930,206	2,975,015	10,905,221	0	10,905,221	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	392	392	1,731,808	1,732,200	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,095,104	7,095,104	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,305,524	78,512,959	101,818,483	-209,375	101,609,108	73.00
74.00	07400	RENAL DIALYSIS	4,165,559	172,988	4,338,547	0	4,338,547	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	107,853,409	-1,001,091	106,852,318	-5,943,469	100,908,849	90.00
91.00	09100	EMERGENCY	32,029,721	461,274	32,490,995	-740,759	31,750,236	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	480,461,140	476,921,914	957,383,054	-691,238	956,691,816	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	0	0	0	691,238	691,238	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	480,461,140	476,921,914	957,383,054	0	957,383,054	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0124

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

Worksheet A

Date/Time Prepared:
6/26/2020 4:52 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	37,862,921	55,688,625	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	10,676,654	17,232,284	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	55,921,562	145,350,249	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	76,170,511	251,547,298	5.00
7.00	00700	OPERATION OF PLANT	-3,655,285	38,463,558	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,359,876	8.00
9.00	00900	HOUSEKEEPING	0	11,176,224	9.00
10.00	01000	DIETARY	0	2,935,453	10.00
11.00	01100	CAFETERIA	0	5,311,394	11.00
13.00	01300	NURSING ADMINISTRATION	388,311	11,167,653	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	29,330,454	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-174,578	8,422,746	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	29,472,347	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	-11,081,196	1,363,997	22.00
23.00	02300	ALLIED HEALTH	0	203,553	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-16,007,813	47,811,249	30.00
31.00	03100	INTENSIVE CARE UNIT	-247,976	8,361,047	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	-477,304	4,490,411	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	-428,850	3,873,354	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	-1,258,259	6,045,662	34.02
34.03	02400	NEURO INTENSIVE CARE	0	2,620,296	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	-152,110	6,630,313	34.04
43.00	04300	NURSERY	0	2,485,818	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-12,517,115	43,807,628	50.00
51.00	05100	RECOVERY ROOM	-351,634	3,037,574	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-274,282	3,111,448	52.00
53.00	05300	ANESTHESIOLOGY	-7,259,294	4,219,737	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-4,156,549	24,782,060	54.00
60.00	06000	LABORATORY	-2,938,792	29,683,484	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	3,789,314	62.00
65.00	06500	RESPIRATORY THERAPY	-2,786,577	7,026,685	65.00
66.00	06600	PHYSICAL THERAPY	0	3,081,240	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,092,384	67.00
68.00	06800	SPEECH PATHOLOGY	0	612,481	68.00
69.00	06900	ELECTROCARDIOLOGY	-2,946,265	7,958,956	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,732,200	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,095,104	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	497,245	102,106,353	73.00
74.00	07400	RENAL DIALYSIS	-1,764,899	2,573,648	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-26,008,780	74,900,069	90.00
91.00	09100	EMERGENCY	-5,277,735	26,472,501	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	81,751,911	1,038,443,727	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.03	19003	SPECIAL FUNDS	0	691,238	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	190.04
194.00	07950	COUNTYCARE	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	81,751,911	1,039,134,965	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 14-0124

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

Worksheet Non-CMS W

Date/Time Prepared:
6/26/2020 4:52 pm

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
21.00	I&R SERVICES-SALARY & FRINGES APPRV	02100		21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	02200		22.00
23.00	ALLIED HEALTH	02300		23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
33.00	BURN INTENSIVE CARE UNIT	03300		33.00
34.00	SURGICAL INTENSIVE CARE UNIT	03400		34.00
34.01	PEDIATRIC INTENSIVE CARE UNIT	02000	PEDIATRIC INTENSIVE CARE UNIT	34.01
34.02	TRAUMA INTENSIVE CARE UNIT	02100	TRAUMA INTENSIVE CARE UNIT	34.02
34.03	NEURO INTENSIVE CARE	02400		34.03
34.04	NEONATAL INTENSIVE CARE UNIT	02060	NEONATAL INTENSIVE CARE UNIT	34.04
43.00	NURSERY	04300		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
60.00	LABORATORY	06000		60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELL	06200		62.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
74.00	RENAL DIALYSIS	07400		74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	09200		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
190.03	SPECIAL FUNDS	19003		190.03
190.04	SENGSTACKE CLINIC	19004		190.04
194.00	COUNTYCARE	07950		194.00
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

RECLASSIFICATIONS

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet A-6
Date/Time Prepared:
6/26/2020 4:52 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - Fringe Benefits to EHW					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,245,062		1.00
	TOTALS		0	3,245,062		
	B - Services Contracts					
1.00	HOUSEKEEPING	9.00		489,247		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00		102,704		2.00
			0	591,951		
	C - Sal of Non Residents					
1.00	I&R SERVICES-OTHER PRGM	22.00	905,493			1.00
	COSTS APPRV		905,493	0		
	D - Peds Algy & Psych to Inp					
1.00	ADULTS & PEDIATRICS	30.00	221,360	28,254		1.00
			221,360	28,254		
	E - Registry and In-House Nsg					
1.00	INTENSIVE CARE UNIT	31.00	128,444	170,837		1.00
2.00	BURN INTENSIVE CARE UNIT	33.00	5,691	26,650		2.00
3.00	SURGICAL INTENSIVE CARE UNIT	34.00	5,691	19,716		3.00
4.00	TRAUMA INTENSIVE CARE UNIT	34.02	15,327	315,865		4.00
5.00	NEURO INTENSIVE CARE	34.03	2,570	42,920		5.00
6.00	DELIVERY ROOM & LABOR ROOM	52.00	11,151	66,132		6.00
7.00	EMERGENCY	91.00	0	2,244		7.00
8.00	CLINIC	90.00	0	4,489		8.00
9.00	NEONATAL INTENSIVE CARE UNIT	34.04	0	3,366		9.00
	TOTALS		168,874	652,219		
	F - Dietary/Cafeteria					
1.00	CAFETERIA	11.00	2,485,333	2,826,061		1.00
			2,485,333	2,826,061		
	G - Hektoen Cost to Research					
1.00	SPECIAL FUNDS	190.03	691,238			1.00
2.00						2.00
3.00						3.00
4.00						4.00
5.00			691,238	0		5.00
	H - Implants					
1.00	IMPL. DEV. CHARGED TO	72.00		7,095,104		1.00
	PATIENTS		0	7,095,104		
	I - HBP Teaching Time					
1.00	I&R SERVICES-OTHER PRGM	22.00	9,117,816	0		1.00
	COSTS APPRV					
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
	TOTALS		9,117,816	0		
	J - Sengstacke					
1.00	CLINIC	90.00		3,161,621		1.00
			0	3,161,621		
	K - Insurance Reclass					
1.00	CAP REL COSTS-BLDG & FIXT	1.00		327,314		1.00
			0	327,314		
	L - Pharmacy School					
1.00	ALLIED HEALTH	23.00	203,553			1.00
			203,553	0		
	M - Medical Director					
1.00	ADMINISTRATIVE & GENERAL	5.00	472,653			1.00
			472,653	0		
	N - I&R Salaries					
1.00	I&R SERVICES-SALARY &	21.00	2,253,829			1.00
	FRINGES APPRV					
2.00						2.00
3.00						3.00
4.00						4.00
5.00			2,253,829	0		5.00
	O - Supplies Reclass					
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	8,826,912		1.00
	PATIENT					
	TOTALS		0	8,826,912		

RECLASSIFICATIONS

Provider CCN: 14-0124

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

Worksheet A-6

Date/Time Prepared:
6/26/2020 4:52 pm

Increases					
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
P - Move Costs from dept 11765 to 21005					
1.00	CLINIC	90.00	794,832	4,758	1.00
			794,832	4,758	
500.00	Grand Total: Increases		17,314,981	26,759,256	500.00

DRAFT

RECLASSIFICATIONS

Provider CCN: 14-0124

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

Worksheet A-6

Date/Time Prepared:
6/26/2020 4:52 pm

		Decreases					6/26/2020 4:32 pm	
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.			
6.00		7.00	8.00	9.00	10.00			
A - Fringe Benefits to EHW								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,245,062	0	1.00		
TOTALS			0	3,245,062				
B - Services Contracts								
1.00	DIETARY	10.00		591,951	1.00			
2.00			0	591,951	2.00			
C - Sal of Non Residents								
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	905,493		1.00			
			905,493	0				
D - Peds Algy & Psych to Inp								
1.00	CLINIC	90.00	221,360	28,254	1.00			
			221,360	28,254				
E - Registry and In-House Nsg								
1.00	ADULTS & PEDIATRICS	30.00	168,874	652,219	0	1.00		
2.00		0.00	0	0	0	2.00		
3.00		0.00	0	0	0	3.00		
4.00		0.00	0	0	0	4.00		
5.00		0.00	0	0	0	5.00		
6.00		0.00	0	0	0	6.00		
7.00		0.00	0	0	0	7.00		
8.00		0.00	0	0	0	8.00		
9.00		0.00	0	0	0	9.00		
TOTALS			168,874	652,219				
F - Dietary/Cafeteria								
1.00	DIETARY	10.00	2,485,333	2,826,061	1.00			
			2,485,333	2,826,061				
G - Hektoen Cost to Research								
1.00	ADMINISTRATIVE & GENERAL	5.00	37,867		1.00			
2.00	ADULTS & PEDIATRICS	30.00	597,801		2.00			
3.00	ANESTHESIOLOGY	53.00	17,187		3.00			
4.00	CLINIC	90.00	32,561		4.00			
5.00	DRUGS CHARGED TO PATIENTS	73.00	5,822		5.00			
			691,238	0				
H - Implants								
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00		7,095,104	1.00			
			0	7,095,104				
I - HBP Teaching Time								
1.00	ADULTS & PEDIATRICS	30.00	888,225	0	0	1.00		
2.00	OPERATING ROOM	50.00	1,307,991	0	0	2.00		
3.00	ANESTHESIOLOGY	53.00	962,119	0	0	3.00		
4.00	RADIOLOGY-DIAGNOSTIC	54.00	657,400	0	0	4.00		
5.00	LABORATORY	60.00	247,261	0	0	5.00		
6.00	CLINIC	90.00	4,382,247	0	0	6.00		
7.00	EMERGENCY	91.00	672,573	0	0	7.00		
TOTALS			9,117,816	0				
J - Sengstacke								
1.00	CLINIC	90.00	3,161,621		1.00			
			3,161,621	0				
K - Insurance Reclass								
1.00	ADMINISTRATIVE & GENERAL	5.00		327,314	12	1.00		
			0	327,314				
L - Pharmacy School								
1.00	DRUGS CHARGED TO PATIENTS	73.00	203,553		1.00			
			203,553	0				
M - Medical Director								
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	472,653		1.00			
			472,653	0				
N - I&R Salaries								
1.00	ADULTS & PEDIATRICS	30.00	46,982		1.00			
2.00	BURN INTENSIVE CARE UNIT	33.00	22,249		2.00			
3.00	RADIOLOGY-DIAGNOSTIC	54.00	31,042		3.00			
4.00	CLINIC	90.00	2,083,126		4.00			
5.00	EMERGENCY	91.00	70,430		5.00			
			2,253,829	0				
O - Supplies Reclass								
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	8,826,912	0	1.00		
TOTALS			0	8,826,912				

RECLASSIFICATIONS

Provider CCN: 14-0124

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

Worksheet A-6

Date/Time Prepared:
6/26/2020 4:52 pm

	Decreases				Wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other		
	6.00	7.00	8.00	9.00	10.00	
	P - Move Costs from dept 11765 to 21005					
1.00	LABORATORY	60.00	794,832	4,758		1.00
			794,832	4,758		
500.00	Grand Total: Decreases		20,476,602	23,597,635		500.00

DRAFT

RECLASSIFICATIONS

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
6/26/2020 4:52 pm

Increases					Decreases				
Cost Center	Line #	Salary	Other		Cost Center	Line #	Salary	Other	
2.00	3.00	4.00	5.00		6.00	7.00	8.00	9.00	
A - Fringe Benefits to EHW									
1.00	EMPLOYEE BENEFITS	4.00	0	3,245,062	ADMINISTRATIVE & GENERAL	5.00	0	3,245,062	1.00
	DEPARTMENT								
	TOTALS		0	3,245,062	TOTALS		0	3,245,062	
B - Services Contracts									
1.00	HOUSEKEEPING	9.00		489,247	DIETARY	10.00		591,951	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00		102,704					2.00
			0	591,951			0	591,951	
C - Sal of Non Residents									
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	905,493		I&R SERVICES-SALARY & FRINGES APPRV	21.00	905,493		1.00
			905,493	0			905,493	0	
D - Peds Algy & Psych to Inp									
1.00	ADULTS & PEDIATRICS	30.00	221,360	28,254	CLINIC	90.00	221,360	28,254	1.00
			221,360	28,254			221,360	28,254	
E - Registry and In-House Nsg									
1.00	INTENSIVE CARE UNIT	31.00	128,444	170,837	ADULTS & PEDIATRICS	30.00	168,874	652,219	1.00
2.00	BURN INTENSIVE CARE UNIT	33.00	5,691	26,650		0.00	0	0	2.00
3.00	SURGICAL INTENSIVE CARE UNIT	34.00	5,691	19,716		0.00	0	0	3.00
4.00	TRAUMA INTENSIVE CARE UNIT	34.02	15,327	315,865		0.00	0	0	4.00
5.00	NEURO INTENSIVE CARE	34.03	2,570	42,920		0.00	0	0	5.00
6.00	DELIVERY ROOM & LABOR ROOM	52.00	11,151	66,132		0.00	0	0	6.00
7.00	EMERGENCY	91.00	0	2,244		0.00	0	0	7.00
8.00	CLINIC	90.00	0	4,489		0.00	0	0	8.00
9.00	NEONATAL INTENSIVE CARE UNIT	34.04	0	3,366		0.00	0	0	9.00
	TOTALS		168,874	652,219	TOTALS		168,874	652,219	
F - Dietary/Cafeteria									
1.00	CAFETERIA	11.00	2,485,333	2,826,061	DIETARY	10.00	2,485,333	2,826,061	1.00
			2,485,333	2,826,061			2,485,333	2,826,061	
G - Hektoen Cost to Research									
1.00	SPECIAL FUNDS	190.03	691,238		ADMINISTRATIVE & GENERAL	5.00	37,867		1.00
2.00					ADULTS & PEDIATRICS	30.00	597,801		2.00
3.00					ANESTHESIOLOGY	53.00	17,187		3.00
4.00					CLINIC	90.00	32,561		4.00
5.00					DRUGS CHARGED TO PATIENTS	73.00	5,822		5.00
			691,238	0			691,238	0	
H - Implants									
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00		7,095,104	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00		7,095,104	1.00
			0	7,095,104			0	7,095,104	
I - HBP Teaching Time									
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	9,117,816	0	ADULTS & PEDIATRICS	30.00	888,225	0	1.00
2.00		0.00	0	0	OPERATING ROOM	50.00	1,307,991	0	2.00
3.00		0.00	0	0	ANESTHESIOLOGY	53.00	962,119	0	3.00
4.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	657,400	0	4.00
5.00		0.00	0	0	LABORATORY	60.00	247,261	0	5.00
6.00		0.00	0	0	CLINIC	90.00	4,382,247	0	6.00
7.00		0.00	0	0	EMERGENCY	91.00	672,573	0	7.00
	TOTALS		9,117,816	0	TOTALS		9,117,816	0	
J - Sengstacke									
1.00	CLINIC	90.00		3,161,621	CLINIC	90.00	3,161,621		1.00
			0	3,161,621			3,161,621	0	
K - Insurance Reclass									
1.00	CAP REL COSTS-BLDG & FIXT	1.00		327,314	ADMINISTRATIVE & GENERAL	5.00		327,314	1.00
			0	327,314			0	327,314	
L - Pharmacy School									
1.00	ALLIED HEALTH	23.00	203,553		DRUGS CHARGED TO PATIENTS	73.00	203,553		1.00
			203,553	0			203,553	0	
M - Medical Director									
1.00	ADMINISTRATIVE & GENERAL	5.00	472,653		I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	472,653		1.00
			472,653	0			472,653	0	

RECLASSIFICATIONS

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
6/26/2020 4:52 pm

Increases					Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
	N - I&R Salaries								
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	2,253,829		ADULTS & PEDIATRICS	30.00	46,982		1.00
2.00					BURN INTENSIVE CARE UNIT	33.00	22,249		2.00
3.00					RADIOLOGY-DIAGNOSTIC CLINIC	54.00	31,042		3.00
4.00					EMERGENCY	90.00	2,083,126		4.00
5.00						91.00	70,430		5.00
			2,253,829	0			2,253,829	0	
	O - Supplies Reclass								
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	8,826,912	CENTRAL SERVICES & SUPPLY	14.00	0	8,826,912	1.00
	TOTALS		0	8,826,912	TOTALS		0	8,826,912	
	P - Move Costs from dept 11765 to 21005								
1.00	CLINIC	90.00	794,832	4,758	LABORATORY	60.00	794,832	4,758	1.00
			794,832	4,758			794,832	4,758	
500.00	Grand Total: Increases		17,314,981	26,759,256	Grand Total: Decreases		20,476,602	23,597,635	500.00

DRAFT

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet A-7
Part I
Date/Time Prepared:
6/26/2020 4:52 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	990,911	0	0	0	0	1.00	
2.00	Land Improvements	2,631,393	0	0	0	0	2.00	
3.00	Buildings and Fixtures	779,784,497	21,063,383	0	21,063,383	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	12,705,848	1,024,139	0	1,024,139	0	5.00	
6.00	Movable Equipment	150,571,063	9,308,621	0	9,308,621	0	6.00	
7.00	HIT designated Assets	10,641,119	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	957,324,831	31,396,143	0	31,396,143	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	957,324,831	31,396,143	0	31,396,143	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	990,911	0				1.00	
2.00	Land Improvements	2,631,393	0				2.00	
3.00	Buildings and Fixtures	800,847,880	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	13,729,987	0				5.00	
6.00	Movable Equipment	159,879,684	0				6.00	
7.00	HIT designated Assets	10,641,119	0				7.00	
8.00	Subtotal (sum of lines 1-7)	988,720,974	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	988,720,974	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet A-7
Part II
Date/Time Prepared:
6/26/2020 4:52 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	17,498,390	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,555,630	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	24,054,020	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	17,498,390				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	6,555,630				2.00
3.00	Total (sum of lines 1-2)	0	24,054,020				3.00

DRAFT

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet A-7
Part III
Date/Time Prepared:
6/26/2020 4:52 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	818,200,170	0	818,200,170	0.827534	0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	170,520,803	0	170,520,803	0.172466	0	2.00	
3.00	Total (sum of lines 1-2)	988,720,973	0	988,720,973	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	16,952,667	0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	6,555,630	0	2.00	
3.00	Total (sum of lines 1-2)	0	0	0	23,508,297	0	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	38,408,644	327,314	0	0	55,688,625	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	10,676,664	0	0	0	17,232,284	2.00	
3.00	Total (sum of lines 1-2)	49,085,298	327,314	0	0	72,920,909	3.00	

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0124

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

Worksheet A-8

Date/Time Prepared:
6/26/2020 4:52 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		B	-440,802	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)						
3.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)						
4.00	Investment income - other (chapter 2)						
5.00	Trade, quantity, and time discounts (chapter 8)						
6.00	Refunds and rebates of expenses (chapter 8)						
7.00	Rental of provider space by suppliers (chapter 8)						
8.00	Telephone services (pay stations excluded) (chapter 21)						
9.00	Television and radio service (chapter 21)						
10.00	Parking lot (chapter 21)	B	-3,655,285	OPERATION OF PLANT	7.00		9.00
11.00	Provider-based physician adjustment	A-8-2	-71,611,369				10.00
12.00	Sale of scrap, waste, etc. (chapter 23)						
13.00	Related organization transactions (chapter 10)	A-8-1	73,468,681				12.00
14.00	Laundry and linen service						
15.00	Cafeteria-employees and guests						
16.00	Rental of quarters to employee and others						
17.00	Sale of medical and surgical supplies to other than patients						
18.00	Sale of drugs to other than patients	B	-388,778	DRUGS CHARGED TO PATIENTS	73.00		17.00
19.00	Sale of medical records and abstracts	B	-174,578	MEDICAL RECORDS & LIBRARY	16.00		18.00
20.00	Nursing and allied health education (tuition, fees, books, etc.)						
21.00	Vending machines						
22.00	Income from imposition of interest, finance or penalty charges (chapter 21)						
23.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments						
24.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		RESPIRATORY THERAPY	65.00		23.00
25.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY	66.00		24.00
26.00	Utilization review - physicians' compensation (chapter 21)			*** Cost Center Deleted ***	114.00		25.00
27.00	Depreciation - CAP REL COSTS-BLDG & FIXT						
28.00	Depreciation - CAP REL COSTS-MVBLE EQUIP						
29.00	Non-physician Anesthetist			*** Cost Center Deleted ***	19.00		28.00
30.00	Physicians' assistant						
30.99	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67.00		30.00
31.00	Hospice (non-distinct) (see instructions)						
31.99	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		ADULTS & PEDIATRICS	30.00		30.99
32.00	CAH HIT Adjustment for Depreciation and Interest						
33.00	Miscellaneous Income	B	-624,869	ADMINISTRATIVE & GENERAL	5.00		33.00

6/26/2020 4:52 pm Y:\15601 - John H Stroger Jr. Hospital of Cook County\300 - Medicare Cost Report\20191130\HFS Files\2019 Stoger

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0124

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

Worksheet A-8

Date/Time Prepared:
6/26/2020 4:52 pm

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33.01 Residency Program Reimbursement	B	-9,324,698	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	33.01
33.02 County Adj for Hospital Bond Int.	A	38,849,446	CAP REL COSTS-BLDG & FIXT	1.00	11	33.02
33.03 County Adj for Hospital Bond Int.	A	10,676,654	CAP REL COSTS-MVBLE EQUIP	2.00	11	33.03
33.04 County Adj for Hospital Bond Int.	A	8,825,763	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.06 CRNA Costs	A	-1,934,946	ANESTHESIOLOGY	53.00	0	33.06
33.07 Remove Sengstacke Clinic	A	-759,108	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.07
33.08 Remove Sengstacke Clinic	A	145,331	DRUGS CHARGED TO PATIENTS	73.00	0	33.08
33.09 Remove Sengstacke Clinic	A	-3,235,393	CLINIC	90.00	0	33.09
33.10 IHA Lobbying	A	-99,067	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11 Non-physician Part B	A	-248,975	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12 Non-physician Part B	A	-1,902,538	ADULTS & PEDIATRICS	30.00	0	33.12
33.13 Non-physician Part B	A	-121,798	SURGICAL INTENSIVE CARE UNIT	34.00	0	33.13
33.14 Non-physician Part B	A	-67,417	NEONATAL INTENSIVE CARE UNIT	34.04	0	33.14
33.15 Non-physician Part B	A	-1,344,253	OPERATING ROOM	50.00	0	33.15
33.16 Non-physician Part B	A	-137,333	OPERATING ROOM	50.00	0	33.16
33.17 Non-physician Part B	A	-274,282	DELIVERY ROOM & LABOR ROOM	52.00	0	33.17
33.18 Non-physician Part B	A	-274,282	LABORATORY	60.00	0	33.18
33.19 Non-physician Part B	A	-125,098	RESPIRATORY THERAPY	65.00	0	33.19
33.20 Non-physician Part B	A	-720,799	ELECTROCARDIOLOGY	69.00	0	33.20
33.21 Non-physician Part B	A	-268,441	RENAL DIALYSIS	74.00	0	33.21
33.22 Non-physician Part B	A	-4,759,208	CLINIC	90.00	0	33.22
33.23 Non-physician Part B	A	-1,095,096	EMERGENCY	91.00	0	33.23
33.24 Oak Forest Vacant Space	A	-545,723	CAP REL COSTS-BLDG & FIXT	1.00	9	33.24
33.25 Pension Adjustment	A	53,920,172	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.25
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		81,751,911				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: 14-0124

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

Worksheet A-8-1

Date/Time Prepared:
6/26/2020 4:52 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	4.00	EMPLOYEE BENEFITS DEPARTMENT	System Health & Hospital - H	3,737,900	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	System Health & Hospital - C	2,341,725	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	System Health & Hospital - A	66,260,053	0	3.00
3.01	13.00	NURSING ADMINISTRATION	System Health & Hospital - N	388,311	0	3.01
3.02	73.00	DRUGS CHARGED TO PATIENTS	System Health & Hospital - P	740,692	0	3.02
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			73,468,681	0	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	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	G	Cook County Health & Hospital	1.00	Cook County Health & Hospital System	1.00	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:	COUNTY OWNED				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: 14-0124

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

Worksheet A-8-1

Date/Time Prepared:
6/26/2020 4:52 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	3,737,900	0		1.00
2.00	2,341,725	0		2.00
3.00	66,260,053	0		3.00
3.01	388,311	0		3.01
3.02	740,692	0		3.02
4.00	0	0		4.00
5.00	73,468,681			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	Government		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: 14-0124

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

Worksheet A-8-2

Date/Time Prepared:

6/26/2020 4:52 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	4.00	EMPLOYEE BENEFITS DEPARTMENT	728,427	728,427	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	533,094	533,094	0	0	0	2.00
3.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	9,117,816	0	9,117,816	211,500	72,395	3.00
4.00	30.00	ADULTS & PEDIATRICS	21,290,496	12,542,821	8,747,675	179,000	75,476	4.00
5.00	31.00	INTENSIVE CARE UNIT	247,976	247,976	0	0	0	5.00
6.00	33.00	BURN INTENSIVE CARE UNIT	477,304	477,304	0	0	0	6.00
7.00	34.00	SURGICAL INTENSIVE CARE UNIT	307,052	307,052	0	0	0	7.00
8.00	34.02	TRAUMA INTENSIVE CARE UNIT	1,258,259	1,258,259	0	0	0	8.00
9.00	34.04	NEONATAL INTENSIVE CARE UNIT	84,693	84,693	0	0	0	9.00
10.00	50.00	OPERATING ROOM	12,843,530	10,649,099	2,194,431	246,400	13,717	10.00
11.00	51.00	RECOVERY ROOM	351,634	351,634	0	0	0	11.00
12.00	53.00	ANESTHESIOLOGY	5,978,215	5,170,222	807,993	239,400	5,064	12.00
13.00	54.00	RADIOLOGY-DIAGNOSTIC	4,875,374	4,021,979	853,395	271,900	4,938	13.00
14.00	60.00	LABORATORY	2,992,961	2,664,510	328,451	260,300	2,706	14.00
15.00	65.00	RESPIRATORY THERAPY	2,661,479	2,661,479	0	0	0	15.00
17.00	69.00	ELECTROCARDIOLOGY	2,225,466	2,225,466	0	0	0	17.00
18.00	74.00	RENAL DIALYSIS	1,496,458	1,496,458	0	0	0	18.00
19.00	90.00	CLINIC	23,520,483	17,183,499	6,336,984	179,000	57,370	19.00
20.00	91.00	EMERGENCY	5,861,329	4,125,428	1,735,901	246,400	12,934	20.00
200.00			96,852,046	66,729,400	30,122,646		244,600	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	55,150	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	40,361	2.00
3.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	7,361,318	368,066	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	6,495,290	324,765	0	0	1,679,185	4.00
5.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	18,775	5.00
6.00	33.00	BURN INTENSIVE CARE UNIT	0	0	0	0	36,137	6.00
7.00	34.00	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	23,247	7.00
8.00	34.02	TRAUMA INTENSIVE CARE UNIT	0	0	0	0	95,265	8.00
9.00	34.04	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	6,412	9.00
10.00	50.00	OPERATING ROOM	1,624,937	81,247	0	0	1,071,434	10.00
11.00	51.00	RECOVERY ROOM	0	0	0	0	26,623	11.00
12.00	53.00	ANESTHESIOLOGY	582,847	29,142	0	0	525,463	12.00
13.00	54.00	RADIOLOGY-DIAGNOSTIC	645,501	32,275	0	0	418,895	13.00
14.00	60.00	LABORATORY	338,640	16,932	0	0	245,322	14.00
15.00	65.00	RESPIRATORY THERAPY	0	0	0	0	201,505	15.00
17.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	168,493	17.00
18.00	74.00	RENAL DIALYSIS	0	0	0	0	113,299	18.00
19.00	90.00	CLINIC	4,937,130	246,857	0	0	2,112,559	19.00
20.00	91.00	EMERGENCY	1,532,181	76,609	0	0	494,692	20.00
200.00			23,517,844	1,175,893	0	0	7,332,817	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	728,427		1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	533,094		2.00
3.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	0	7,361,318	1,756,498	1,756,498		3.00
4.00	30.00	ADULTS & PEDIATRICS	689,931	7,185,221	1,562,454	14,105,275		4.00
5.00	31.00	INTENSIVE CARE UNIT	0	0	0	247,976		5.00
6.00	33.00	BURN INTENSIVE CARE UNIT	0	0	0	477,304		6.00
7.00	34.00	SURGICAL INTENSIVE CARE UNIT	0	0	0	307,052		7.00
8.00	34.02	TRAUMA INTENSIVE CARE UNIT	0	0	0	1,258,259		8.00
9.00	34.04	NEONATAL INTENSIVE CARE UNIT	0	0	0	84,693		9.00
10.00	50.00	OPERATING ROOM	183,064	1,808,001	386,430	11,035,529		10.00
11.00	51.00	RECOVERY ROOM	0	0	0	351,634		11.00
12.00	53.00	ANESTHESIOLOGY	71,020	653,867	154,126	5,324,348		12.00
13.00	54.00	RADIOLOGY-DIAGNOSTIC	73,324	718,825	134,570	4,156,549		13.00
14.00	60.00	LABORATORY	26,922	365,562	0	2,664,510		14.00
15.00	65.00	RESPIRATORY THERAPY	0	0	0	2,661,479		15.00
17.00	69.00	ELECTROCARDIOLOGY	0	0	0	2,225,466		17.00
18.00	74.00	RENAL DIALYSIS	0	0	0	1,496,458		18.00
19.00	90.00	CLINIC	569,174	5,506,304	830,680	18,014,179		19.00
20.00	91.00	EMERGENCY	146,509	1,678,690	57,211	4,182,639		20.00
200.00			1,759,944	25,277,788	4,881,969	71,611,369		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet B
Part I
Date/Time Prepared:
6/26/2020 4:52 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
Net Expenses for Cost Allocation (from Wkst A col. 7)							
0			1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	55,688,625	55,688,625			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	17,232,284	17,232,284			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	145,350,249	447,522	34,369	145,832,140	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	251,547,298	8,330,236	2,733,280	7,329,831	5.00
7.00	00700	OPERATION OF PLANT	38,463,558	19,889,564	832,438	5,013,616	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,359,876	410,049	352	0	8.00
9.00	00900	HOUSEKEEPING	11,176,224	439,264	5,356	2,860,453	9.00
10.00	01000	DIETARY	2,935,453	23,555	883	506,552	10.00
11.00	01100	CAFETERIA	5,311,394	984,164	26,177	762,741	11.00
13.00	01300	NURSING ADMINISTRATION	11,167,653	267,947	245,771	1,836,264	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	29,330,454	1,551,332	342,223	1,350,136	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,422,746	703,375	1,907	1,166,137	16.00
17.00	01700	SOCIAL SERVICE	0	84,630	344	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	29,472,347	24,304	2,213	7,962,290	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	1,363,997	0	0	3,495,603	22.00
23.00	02300	ALLIED HEALTH	203,553	2,924	0	62,470	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	47,811,249	6,458,350	4,337,106	18,259,101	30.00
31.00	03100	INTENSIVE CARE UNIT	8,361,047	656,148	0	2,588,349	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	4,499,411	140,067	290	1,516,222	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	3,873,354	220,697	0	1,314,283	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	6,045,662	530,607	420,552	2,058,079	34.02
34.03	02400	NEURO INTENSIVE CARE	2,620,296	110,875	0	790,696	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	6,638,313	282,730	32,926	2,082,896	34.04
43.00	04300	NURSERY	2,485,818	202,264	0	765,055	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	43,807,628	1,618,932	4,286,402	12,636,180	50.00
51.00	05100	RECOVERY ROOM	3,037,574	312,390	2,276	1,039,351	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,111,448	309,513	0	1,018,478	52.00
53.00	05300	ANESTHESIOLOGY	4,219,737	107,951	814,436	3,434,035	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,782,060	2,197,632	218,572	6,098,493	54.00
60.00	06000	LABORATORY	29,683,484	1,799,490	480,568	4,704,909	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	3,789,314	64,513	6,128	305,068	62.00
65.00	06500	RESPIRATORY THERAPY	7,026,685	128,839	321,878	2,610,752	65.00
66.00	06600	PHYSICAL THERAPY	3,081,240	107,834	3,874	870,635	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,092,384	103,717	0	320,339	67.00
68.00	06800	SPEECH PATHOLOGY	612,481	53,472	9,005	147,527	68.00
69.00	06900	ELECTROCARDIOLOGY	7,958,956	497,275	1,057,934	2,433,756	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,732,200	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,095,104	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	102,106,353	268,602	27,903	7,088,139	73.00
74.00	07400	RENAL DIALYSIS	2,573,648	54,408	20,803	1,278,398	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	74,900,069	4,411,030	765,953	30,311,367	90.00
91.00	09100	EMERGENCY	26,472,501	1,687,726	200,365	9,601,800	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,038,443,727	55,483,928	17,232,284	145,620,001	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	691,238	144,488	0	212,139	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	190.04
194.00	07950	COUNTYCARE	0	60,209	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,039,134,965	55,688,625	17,232,284	145,832,140	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet B
Part I
Date/Time Prepared:
6/26/2020 4:52 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	269,940,645					5.00
7.00	00700	OPERATION OF PLANT	22,529,995	86,729,171				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	621,259	1,316,117	3,707,653			8.00
9.00	00900	HOUSEKEEPING	5,082,052	1,409,889	0	20,973,238		9.00
10.00	01000	DIETARY	1,216,510	75,604	0	18,876	4,777,433	10.00
11.00	01100	CAFETERIA	2,486,219	3,158,831	0	788,672	0	11.00
13.00	01300	NURSING ADMINISTRATION	4,743,865	860,018	0	214,722	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,431,538	4,979,246	0	1,243,178	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,612,624	2,257,595	0	563,658	0	16.00
17.00	01700	SOCIAL SERVICE	29,821	271,632	0	67,819	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	13,146,580	78,006	0	19,476	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	1,705,423	0	0	0	0	22.00
23.00	02300	ALLIED HEALTH	94,384	9,385	0	2,343	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	26,975,209	20,729,103	1,016,245	5,175,475	3,377,868	30.00
31.00	03100	INTENSIVE CARE UNIT	4,072,838	2,106,012	149,717	525,812	223,438	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	2,160,377	449,567	113,511	112,244	40,370	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,897,995	708,361	153,354	176,858	73,030	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	3,177,718	1,703,069	169,603	425,209	44,139	34.02
34.03	02400	NEURO INTENSIVE CARE	1,235,960	355,870	14,149	88,851	65,063	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	3,171,388	907,467	134,661	226,569	0	34.04
43.00	04300	NURSERY	1,211,840	649,199	47,279	162,087	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	21,880,746	5,196,221	515,916	1,297,351	0	50.00
51.00	05100	RECOVERY ROOM	1,541,181	1,002,666	164,234	250,338	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,557,972	993,432	202,827	248,032	0	52.00
53.00	05300	ANESTHESIOLOGY	3,009,709	346,485	26,202	86,508	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,685,131	7,053,650	378,868	1,761,099	0	54.00
60.00	06000	LABORATORY	12,868,390	5,775,748	0	1,442,043	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,461,669	207,065	0	51,698	0	62.00
65.00	06500	RESPIRATORY THERAPY	3,540,327	413,529	0	103,247	0	65.00
66.00	06600	PHYSICAL THERAPY	1,426,070	346,109	29,807	86,414	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	532,178	332,896	0	83,115	0	67.00
68.00	06800	SPEECH PATHOLOGY	288,642	171,628	0	42,851	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,192,991	1,596,083	41,080	398,497	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	607,897	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,489,949	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	38,424,661	862,120	0	215,247	0	73.00
74.00	07400	RENAL DIALYSIS	1,378,228	174,631	0	43,601	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	38,739,958	14,157,903	24,463	3,534,832	291,050	90.00
91.00	09100	EMERGENCY	13,322,484	5,417,026	525,737	1,352,480	662,475	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	269,551,778	86,072,163	3,707,653	20,809,202	4,777,433	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	367,737	463,757	0	115,787	0	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	21,130	193,251	0	48,249	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	269,940,645	86,729,171	3,707,653	20,973,238	4,777,433	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet B
Part I
Date/Time Prepared:
6/26/2020 4:52 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			11.00	13.00	14.00	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
11.00	01100	CAFETERIA	13,518,198					11.00
13.00	01300	NURSING ADMINISTRATION	160,922	19,497,162				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	285,085	542,091	51,055,283			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	189,823	365,990		17,283,855		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	454,246	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,382,490	24,967	463	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	187,217	75,309	142	0	0	22.00
23.00	02300	ALLIED HEALTH	14,670	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,141,856	3,273,705	9,445	2,471,303	143,036	30.00
31.00	03100	INTENSIVE CARE UNIT	324,750	607,872	2,023	314,843	11,211	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	141,691	247,018	0	50,772	5,581	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	117,938	207,669	0	108,383	8,412	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	192,811	312,792	3,377	99,218	8,412	34.02
34.03	02400	NEURO INTENSIVE CARE	87,801	169,113	0	69,413	8,412	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	208,948	391,675	0	236,287	8,412	34.04
43.00	04300	NURSERY	99,552	191,942	0	21,581	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,010,598	1,534,935	5,708,365	2,340,153	0	50.00
51.00	05100	RECOVERY ROOM	113,391	209,441	0	189,997	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	119,281	227,658	0	28,572	0	52.00
53.00	05300	ANESTHESIOLOGY	148,055	135,092	80,220	794,341	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	570,996	931,304	642,642	2,306,515	0	54.00
60.00	06000	LABORATORY	554,662	933,674	4,010,336	1,914,864	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	38,282	70,275	863,720	87,256	0	62.00
65.00	06500	RESPIRATORY THERAPY	261,152	387,971	161,201	136,670	0	65.00
66.00	06600	PHYSICAL THERAPY	108,674	200,111	64,284	106,367	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	46,789	86,194	0	42,864	0	67.00
68.00	06800	SPEECH PATHOLOGY	18,130	34,956	0	20,090	0	68.00
69.00	06900	ELECTROCARDIOLOGY	170,878	238,778	709,053	477,693	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	205	149,502	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	255,682	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	841,354	1,443,358	38,791,560	2,553,421	0	73.00
74.00	07400	RENAL DIALYSIS	100,318	131,834	0	126,830	16,824	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,963,946	5,071,972	0	1,559,870	159,826	90.00
91.00	09100	EMERGENCY	902,696	1,449,466	8,247	821,368	84,120	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,504,757	19,497,162	51,055,283	17,283,855	454,246	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	13,441	0	0	0	0	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	13,518,198	19,497,162	51,055,283	17,283,855	454,246	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet B
Part I
Date/Time Prepared:
6/26/2020 4:52 pm

Cost Center Description			INTERNS & RESIDENTS		ALLIED HEALTH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00				
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
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	52,113,136					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		6,827,691				22.00
23.00	02300	ALLIED HEALTH			389,729			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,883,461	1,556,932	0	155,619,444	-13,440,393	30.00
31.00	03100	INTENSIVE CARE UNIT	1,836,952	240,671	0	22,021,683	-2,077,623	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	368,699	48,306	0	9,894,126	-417,005	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	535,596	70,172	0	9,466,102	-605,768	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	0	0	0	15,191,248	0	34.02
34.03	02400	NEURO INTENSIVE CARE	81,812	10,719	0	5,709,030	-92,531	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	981,744	128,625	0	15,432,642	-1,110,369	34.04
43.00	04300	NURSERY	303,250	39,731	0	6,179,598	-342,981	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,715,702	1,141,903	0	111,691,032	-9,857,605	50.00
51.00	05100	RECOVERY ROOM	0	0	0	7,862,839	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	694,856	91,038	0	8,603,107	-785,894	52.00
53.00	05300	ANESTHESIOLOGY	3,402,287	445,756	0	17,050,814	-3,848,043	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,188,198	286,690	0	61,101,850	-2,474,888	54.00
60.00	06000	LABORATORY	1,122,460	147,061	0	65,437,689	-1,269,521	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	6,944,988	0	62.00
65.00	06500	RESPIRATORY THERAPY	955,564	125,195	0	16,173,010	-1,080,759	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,431,419	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,640,476	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,398,782	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,394,076	182,647	0	21,349,697	-1,576,723	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,489,804	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9,840,735	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	111,264	14,577	389,729	193,138,288	-125,841	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	5,899,523	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	8,586,985	1,125,038	0	186,604,262	-9,712,023	90.00
91.00	09100	EMERGENCY	8,950,230	1,172,630	0	72,631,351	-10,122,860	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52,113,136	6,827,691	389,729	1,036,803,539	-58,940,827	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	0	0	0	2,008,587	0	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	0	0	0	322,839	0	194.00
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)	52,113,136	6,827,691	389,729	1,039,134,965	-58,940,827	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet B
Part I
Date/Time Prepared:
6/26/2020 4:52 pm

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	ALLIED HEALTH	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	34.02
34.03	02400	NEURO INTENSIVE CARE	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	34.04
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
190.03	19003	SPECIAL FUNDS	190.03
190.04	19004	SENGSTACKE CLINIC	190.04
194.00	07950	COUNTYCARE	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
1.00	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-1	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	5	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	6	MEALS SERVED	10.00
11.00	CAFETERIA	7	HOURS	11.00
13.00	NURSING ADMINISTRATION	9	DIRECT NRSING HRS	13.00
14.00	CENTRAL SERVICES & SUPPLY	10	COSTED REQUIS.	14.00
16.00	MEDICAL RECORDS & LIBRARY	C	GROSS CHAR GES	16.00
17.00	SOCIAL SERVICE	13	TIME SPENT	17.00
21.00	I&R SERVICES-SALARY & FRINGES APPRV	15	ASSIGNED TIME	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	15	ASSIGNED TIME	22.00
23.00	ALLIED HEALTH	23	ASSIGNED TIME	23.00

DRAFT

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet B
Part II
Date/Time Prepared:
6/26/2020 4:52 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	447,522	34,369	481,891	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	22,449,912	8,330,236	2,733,280	33,513,428	5.00
7.00	00700	OPERATION OF PLANT	0	19,889,564	832,438	20,722,002	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	410,049	352	410,401	8.00
9.00	00900	HOUSEKEEPING	0	439,264	5,356	444,620	9.00
10.00	01000	DIETARY	0	23,555	883	24,438	10.00
11.00	01100	CAFETERIA	0	984,164	26,177	1,010,341	11.00
13.00	01300	NURSING ADMINISTRATION	0	267,947	245,771	513,718	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	771,612	1,551,332	342,223	2,665,167	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	703,375	1,907	705,282	16.00
17.00	01700	SOCIAL SERVICE	0	84,630	344	84,974	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	24,304	2,213	26,517	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	ALLIED HEALTH	0	2,924	0	2,924	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	6,458,350	4,337,106	10,795,456	30.00
31.00	03100	INTENSIVE CARE UNIT	0	656,148	0	656,148	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	140,067	290	140,357	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	220,697	0	220,697	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	0	530,607	420,552	951,159	34.02
34.03	02400	NEURO INTENSIVE CARE	0	110,875	0	110,875	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	0	282,730	32,926	315,656	34.04
43.00	04300	NURSERY	0	202,264	0	202,264	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,618,932	4,286,402	5,905,334	50.00
51.00	05100	RECOVERY ROOM	0	312,390	2,276	314,666	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	309,513	0	309,513	52.00
53.00	05300	ANESTHESIOLOGY	0	107,951	814,436	922,387	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	402,252	2,197,632	218,572	2,818,456	54.00
60.00	06000	LABORATORY	0	1,799,490	480,568	2,280,058	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	64,513	6,128	70,641	62.00
65.00	06500	RESPIRATORY THERAPY	521,764	128,839	321,878	972,481	65.00
66.00	06600	PHYSICAL THERAPY	0	107,834	3,874	111,708	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	103,717	0	103,717	67.00
68.00	06800	SPEECH PATHOLOGY	0	53,472	9,005	62,477	68.00
69.00	06900	ELECTROCARDIOLOGY	66,723	497,275	1,057,934	1,621,932	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	1,408,610	268,602	27,903	1,705,115	73.00
74.00	07400	RENAL DIALYSIS	0	54,408	20,803	75,211	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,353,086	4,411,030	765,953	6,530,069	90.00
91.00	09100	EMERGENCY	0	1,687,726	200,365	1,888,091	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,973,959	55,483,928	17,232,284	99,690,171	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	0	144,488	0	144,488	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	190.04
194.00	07950	COUNTYCARE	0	60,209	0	60,209	194.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	26,973,959	55,688,625	17,232,284	99,894,868	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet B
Part II
Date/Time Prepared:
6/26/2020 4:52 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	33,537,646				5.00
7.00	00700	OPERATION OF PLANT	2,799,148	23,537,715			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	77,186	357,185	844,772		8.00
9.00	00900	HOUSEKEEPING	631,399	382,634	0	1,468,104	9.00
10.00	01000	DIETARY	151,140	20,518	0	1,321	199,091 10.00
11.00	01100	CAFETERIA	308,890	857,285	0	55,206	0 11.00
13.00	01300	NURSING ADMINISTRATION	589,382	233,403	0	15,030	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,420,265	1,351,334	0	87,021	0 14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	448,836	612,696	0	39,455	0 16.00
17.00	01700	SOCIAL SERVICE	3,705	73,719	0	4,747	0 17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,633,344	21,170	0	1,363	0 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	211,883	0	0	0	0 22.00
23.00	02300	ALLIED HEALTH	11,726	2,547	0	164	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,351,426	5,625,741	231,548	362,282	140,769 30.00
31.00	03100	INTENSIVE CARE UNIT	506,013	571,558	34,112	36,806	9,311 31.00
33.00	03300	BURN INTENSIVE CARE UNIT	268,407	122,009	25,863	7,857	1,682 33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	235,809	192,244	34,941	12,380	3,043 34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	0 34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	394,803	462,201	38,643	29,764	1,839 34.02
34.03	02400	NEURO INTENSIVE CARE	153,557	96,581	3,224	6,219	2,711 34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	394,016	246,281	30,682	15,860	0 34.04
43.00	04300	NURSERY	150,560	176,188	10,772	11,346	0 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,718,485	1,410,220	117,549	90,813	0 50.00
51.00	05100	RECOVERY ROOM	191,478	272,117	37,420	17,523	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	193,564	269,611	46,213	17,362	0 52.00
53.00	05300	ANESTHESIOLOGY	373,929	94,034	5,970	6,055	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,451,772	1,914,313	86,323	123,275	0 54.00
60.00	06000	LABORATORY	1,598,781	1,567,499	0	100,941	0 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	181,599	56,196	0	3,619	0 62.00
65.00	06500	RESPIRATORY THERAPY	439,854	112,229	0	7,227	0 65.00
66.00	06600	PHYSICAL THERAPY	177,176	93,932	6,791	6,049	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	66,118	90,346	0	5,818	0 67.00
68.00	06800	SPEECH PATHOLOGY	35,861	46,579	0	3,000	0 68.00
69.00	06900	ELECTROCARDIOLOGY	520,941	433,166	9,360	27,894	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	75,526	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	309,354	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,773,917	233,974	0	15,067	0 73.00
74.00	07400	RENAL DIALYSIS	171,232	47,394	0	3,052	0 74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	4,813,053	3,842,360	5,574	247,434	12,129 90.00
91.00	09100	EMERGENCY	1,655,198	1,470,144	119,787	94,672	27,607 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,489,333	23,359,408	844,772	1,456,622	199,091 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
190.03	19003	SPECIAL FUNDS	45,688	125,860	0	8,105	0 190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0 190.04
194.00	07950	COUNTYCARE	2,625	52,447	0	3,377	0 194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	33,537,646	23,537,715	844,772	1,468,104	199,091 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet B
Part II
Date/Time Prepared:
6/26/2020 4:52 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		11.00	13.00	14.00	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
11.00	01100	CAFETERIA	2,234,242				11.00
13.00	01300	NURSING ADMINISTRATION	26,597	1,384,197			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	47,118	38,486	5,613,852		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	31,373	25,983	0	1,867,478	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	228,493	1,772	51	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	30,943	5,347	16	0	22.00
23.00	02300	ALLIED HEALTH	2,425	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	353,999	232,416	1,039	267,040	30.00
31.00	03100	INTENSIVE CARE UNIT	53,674	43,156	222	34,021	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	23,418	17,537	0	5,486	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	19,492	14,743	0	11,711	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	31,867	22,207	371	10,721	34.02
34.03	02400	NEURO INTENSIVE CARE	14,512	12,006	0	7,500	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	34,534	27,807	0	25,532	34.04
43.00	04300	NURSERY	16,454	13,627	0	2,332	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	167,028	108,972	627,670	252,868	50.00
51.00	05100	RECOVERY ROOM	18,741	14,869	0	20,530	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	19,714	16,163	0	3,087	52.00
53.00	05300	ANESTHESIOLOGY	24,470	9,591	8,821	85,834	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	94,372	66,118	70,662	249,233	54.00
60.00	06000	LABORATORY	91,673	66,286	440,961	206,913	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	6,327	4,989	94,971	9,429	62.00
65.00	06500	RESPIRATORY THERAPY	43,162	27,544	17,725	14,768	65.00
66.00	06600	PHYSICAL THERAPY	17,961	14,207	7,068	11,494	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,733	6,119	0	4,632	67.00
68.00	06800	SPEECH PATHOLOGY	2,997	2,482	0	2,171	68.00
69.00	06900	ELECTROCARDIOLOGY	28,242	16,952	77,965	51,618	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	22	16,155	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	27,628	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	139,056	102,471	4,265,381	275,762	73.00
74.00	07400	RENAL DIALYSIS	16,580	9,359	0	13,705	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	489,871	360,083	0	168,554	90.00
91.00	09100	EMERGENCY	149,195	102,905	907	88,754	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,232,021	1,384,197	5,613,852	1,867,478	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	2,221	0	0	0	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	190.04
194.00	07950	COUNTYCARE	0	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,234,242	1,384,197	5,613,852	1,867,478	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet B
Part II
Date/Time Prepared:
6/26/2020 4:52 pm

Cost Center Description		INTERNS & RESIDENTS		ALLIED HEALTH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
		21.00	22.00				
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
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,939,018				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		259,739			22.00
23.00	02300	ALLIED HEALTH			19,992		23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS			21,474,677	0	30.00
31.00	03100	INTENSIVE CARE UNIT			1,957,698	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT			619,680	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT			752,497	0	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT			0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT			1,953,470	0	34.02
34.03	02400	NEURO INTENSIVE CARE			412,892	0	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT			1,100,345	0	34.04
43.00	04300	NURSERY			586,071	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM			11,440,689	0	50.00
51.00	05100	RECOVERY ROOM			890,778	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM			878,592	0	52.00
53.00	05300	ANESTHESIOLOGY			1,542,437	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC			6,894,674	0	54.00
60.00	06000	LABORATORY			6,368,657	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL			428,779	0	62.00
65.00	06500	RESPIRATORY THERAPY			1,643,616	0	65.00
66.00	06600	PHYSICAL THERAPY			449,263	0	66.00
67.00	06700	OCCUPATIONAL THERAPY			285,541	0	67.00
68.00	06800	SPEECH PATHOLOGY			156,054	0	68.00
69.00	06900	ELECTROCARDIOLOGY			2,796,111	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT			91,703	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS			336,982	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS			11,534,162	0	73.00
74.00	07400	RENAL DIALYSIS			346,948	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC			16,628,144	0	90.00
91.00	09100	EMERGENCY			5,659,938	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	97,230,398	0 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN			0	0	190.00
190.03	19003	SPECIAL FUNDS			327,063	0	190.03
190.04	19004	SENGSTACKE CLINIC			0	0	190.04
194.00	07950	COUNTYCARE			118,658	0	194.00
200.00		Cross Foot Adjustments	1,939,018	259,739	19,992	2,218,749	0 200.00
201.00		Negative Cost Centers	0	0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	1,939,018	259,739	19,992	99,894,868	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet B
Part II
Date/Time Prepared:
6/26/2020 4:52 pm

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	ALLIED HEALTH	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	34.02
34.03	02400	NEURO INTENSIVE CARE	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	34.04
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
190.03	19003	SPECIAL FUNDS	190.03
190.04	19004	SENGSTACKE CLINIC	190.04
194.00	07950	COUNTYCARE	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0124

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

Worksheet B-1

Date/Time Prepared:
6/26/2020 4:52 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,380,745				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		6,361,062			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	19,132	12,687	475,182,776		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	356,126	1,008,953	23,883,684	-269,940,645	5.00
7.00	00700	OPERATION OF PLANT	850,299	307,283	16,336,479	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,530	130	0	0	8.00
9.00	00900	HOUSEKEEPING	18,779	1,977	9,320,564	0	9.00
10.00	01000	DIETARY	1,007	326	1,650,560	0	10.00
11.00	01100	CAFETERIA	42,074	9,663	2,485,333	0	11.00
13.00	01300	NURSING ADMINISTRATION	11,455	90,723	5,983,322	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	66,321	126,327	4,399,314	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	30,070	704	3,799,766	0	16.00
17.00	01700	SOCIAL SERVICE	3,618	127	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,039	817	25,944,503	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	11,390,150	0	22.00
23.00	02300	ALLIED HEALTH	125	0	203,553	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	276,101	1,600,983	59,495,861	0	30.00
31.00	03100	INTENSIVE CARE UNIT	28,051	0	8,433,933	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	5,988	107	4,940,492	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	9,435	0	4,282,488	0	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	22,684	155,241	6,706,090	0	34.02
34.03	02400	NEURO INTENSIVE CARE	4,740	0	2,576,421	0	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	12,087	12,154	6,786,954	0	34.04
43.00	04300	NURSERY	8,647	0	2,492,872	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	69,211	1,582,267	41,174,011	0	50.00
51.00	05100	RECOVERY ROOM	13,355	840	3,386,645	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,232	0	3,318,631	0	52.00
53.00	05300	ANESTHESIOLOGY	4,615	300,638	11,189,535	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	93,951	80,683	19,871,464	0	54.00
60.00	06000	LABORATORY	76,930	177,395	15,330,579	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,758	2,262	994,040	0	62.00
65.00	06500	RESPIRATORY THERAPY	5,508	118,817	8,506,933	0	65.00
66.00	06600	PHYSICAL THERAPY	4,610	1,430	2,836,898	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,434	0	1,043,801	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,286	3,324	480,704	0	68.00
69.00	06900	ELECTROCARDIOLOGY	21,259	390,522	7,930,206	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,483	10,300	23,096,149	0	73.00
74.00	07400	RENAL DIALYSIS	2,326	7,679	4,165,559	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	188,576	282,741	98,767,326	0	90.00
91.00	09100	EMERGENCY	72,152	73,962	31,286,718	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,371,994	6,361,062	474,491,538	-269,940,645	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	6,177	0	691,238	0	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	190.04
194.00	07950	COUNTYCARE	2,574	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	55,688,625	17,232,284	145,832,140	269,940,645	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.391260	2.709026	0.306897	0.350939	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			481,891	33,537,646	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001014	0.043601	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: 14-0124

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

Worksheet B-1

Date/Time Prepared:
6/26/2020 4:52 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
		7.00	8.00	9.00	10.00	11.00	
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	1,155,188				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,530	2,232,635			8.00
9.00	00900	HOUSEKEEPING	18,779	0	1,118,879		9.00
10.00	01000	DIETARY	1,007	0	1,007	223,073	10.00
11.00	01100	CAFETERIA	42,074	0	42,074	0	11.00
13.00	01300	NURSING ADMINISTRATION	11,455	0	11,455	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	66,321	0	66,321	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	30,070	0	30,070	0	16.00
17.00	01700	SOCIAL SERVICE	3,618	0	3,618	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,039	0	1,039	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	ALLIED HEALTH	125	0	125	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	276,101	611,950	276,101	157,723	30.00
31.00	03100	INTENSIVE CARE UNIT	28,051	90,155	28,051	10,433	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	5,988	68,353	5,988	1,885	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	9,435	92,345	9,435	3,410	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	22,684	102,130	22,684	2,061	34.02
34.03	02400	NEURO INTENSIVE CARE	4,740	8,520	4,740	3,038	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	12,087	81,089	12,087	0	34.04
43.00	04300	NURSERY	8,647	28,470	8,647	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	69,211	310,669	69,211	0	50.00
51.00	05100	RECOVERY ROOM	13,355	98,897	13,355	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,232	122,136	13,232	0	52.00
53.00	05300	ANESTHESIOLOGY	4,615	15,778	4,615	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	93,951	228,143	93,951	0	54.00
60.00	06000	LABORATORY	76,930	0	76,930	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,758	0	2,758	0	62.00
65.00	06500	RESPIRATORY THERAPY	5,508	0	5,508	0	65.00
66.00	06600	PHYSICAL THERAPY	4,610	17,949	4,610	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,434	0	4,434	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,286	0	2,286	0	68.00
69.00	06900	ELECTROCARDIOLOGY	21,259	24,737	21,259	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,483	0	11,483	0	73.00
74.00	07400	RENAL DIALYSIS	2,326	0	2,326	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	188,576	14,731	188,576	13,590	90.00
91.00	09100	EMERGENCY	72,152	316,583	72,152	30,933	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,146,437	2,232,635	1,110,128	223,073	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	6,177	0	6,177	0	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	190.04
194.00	07950	COUNTYCARE	2,574	0	2,574	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	86,729,171	3,707,653	20,973,238	4,777,433	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	75.077971	1.660662	18.744867	21.416456	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	23,537,715	844,772	1,468,104	199,091	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	20.375657	0.378374	1.312120	0.892493	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: 14-0124

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

Worksheet B-1

Date/Time Prepared:
6/26/2020 4:52 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	SOCIAL SERVICE (TIME SPENT)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
		13.00	14.00	16.00	17.00	21.00	
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
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	6,294,292				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	175,004	97,826,072			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	118,153	0	1,381,423,848		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	56,160	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	8,060	888	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	24,312	273	0	47,774	22.00
23.00	02300	ALLIED HEALTH	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,056,854	18,097	197,514,597	17,684	30.00
31.00	03100	INTENSIVE CARE UNIT	196,240	3,876	25,163,300	1,386	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	79,745	0	4,057,900	690	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	67,042	0	8,662,300	1,040	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	100,979	6,471	7,929,800	1,040	34.02
34.03	02400	NEURO INTENSIVE CARE	54,595	0	5,547,700	1,040	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	126,445	0	18,884,800	1,040	34.04
43.00	04300	NURSERY	61,965	0	1,724,800	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	495,525	10,937,681	187,032,664	0	50.00
51.00	05100	RECOVERY ROOM	67,614	0	15,185,200	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	73,495	0	2,283,603	0	52.00
53.00	05300	ANESTHESIOLOGY	43,612	153,707	63,486,319	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	300,654	1,231,353	184,344,206	0	54.00
60.00	06000	LABORATORY	301,419	7,684,123	153,042,238	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	22,687	1,654,956	6,973,808	0	62.00
65.00	06500	RESPIRATORY THERAPY	125,249	308,874	10,923,080	0	65.00
66.00	06600	PHYSICAL THERAPY	64,602	123,173	8,501,164	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	27,826	0	3,425,858	0	67.00
68.00	06800	SPEECH PATHOLOGY	11,285	0	1,605,655	0	68.00
69.00	06900	ELECTROCARDIOLOGY	77,085	1,358,601	38,178,800	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	392	11,948,714	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	20,434,928	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	465,961	74,327,805	204,119,398	0	73.00
74.00	07400	RENAL DIALYSIS	42,560	0	10,136,688	2,080	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,637,391	0	124,669,914	19,760	90.00
91.00	09100	EMERGENCY	467,933	15,802	65,646,414	10,400	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,294,292	97,826,072	1,381,423,848	56,160	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	0	0	0	0	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	190.04
194.00	07950	COUNTYCARE	0	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	19,497,162	51,055,283	17,283,855	454,246	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.097594	0.521899	0.012512	8.088426	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,384,197	5,613,852	1,867,478	167,145	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.219913	0.057386	0.001352	2.976229	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: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet B-1
Date/Time Prepared:
6/26/2020 4:52 pm

Cost Center Description		INTERNS & RESIDENTS	ALLIED HEALTH (ASSIGNED TIME)	
		SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
		22.00	23.00	
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
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	47,774	22.00
23.00	02300	ALLIED HEALTH	10,000	23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	10,894	30.00
31.00	03100	INTENSIVE CARE UNIT	1,684	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	338	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	491	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	0	34.02
34.03	02400	NEURO INTENSIVE CARE	75	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	900	34.04
43.00	04300	NURSERY	278	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	7,990	50.00
51.00	05100	RECOVERY ROOM	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	637	52.00
53.00	05300	ANESTHESIOLOGY	3,119	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,006	54.00
60.00	06000	LABORATORY	1,029	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	62.00
65.00	06500	RESPIRATORY THERAPY	876	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,278	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	102	73.00
74.00	07400	RENAL DIALYSIS	0	74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	7,872	90.00
91.00	09100	EMERGENCY	8,205	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	47,774	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
190.03	19003	SPECIAL FUNDS	0	190.03
190.04	19004	SENGSTACKE CLINIC	0	190.04
194.00	07950	COUNTYCARE	0	194.00
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,827,691	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	142.916461	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	259,739	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.436828	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet C
Part I
Date/Time Prepared:
6/26/2020 4:52 pm

			Title XVIII	Hospital	PPS			
Cost Center Description			Therapy Limit Adj.	Costs				
				Total Costs	RCE Disallowance		Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	142,179,051		142,179,051	1,562,454	143,741,505	30.00
31.00	03100	INTENSIVE CARE UNIT	19,944,060		19,944,060	0	19,944,060	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	9,477,121		9,477,121	0	9,477,121	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	8,860,334		8,860,334	0	8,860,334	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0		0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	15,191,248		15,191,248	0	15,191,248	34.02
34.03	02400	NEURO INTENSIVE CARE	5,616,499		5,616,499	0	5,616,499	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	14,322,273		14,322,273	0	14,322,273	34.04
43.00	04300	NURSERY	5,836,617		5,836,617	0	5,836,617	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	101,833,427		101,833,427	386,430	102,219,857	50.00
51.00	05100	RECOVERY ROOM	7,862,839		7,862,839	0	7,862,839	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,817,213		7,817,213	0	7,817,213	52.00
53.00	05300	ANESTHESIOLOGY	13,202,771		13,202,771	154,126	13,356,897	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	58,626,962		58,626,962	134,570	58,761,532	54.00
60.00	06000	LABORATORY	64,168,168		64,168,168	0	64,168,168	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	6,944,988		6,944,988	0	6,944,988	62.00
65.00	06500	RESPIRATORY THERAPY	15,092,251	0	15,092,251	0	15,092,251	65.00
66.00	06600	PHYSICAL THERAPY	6,431,419	0	6,431,419	0	6,431,419	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,640,476	0	2,640,476	0	2,640,476	67.00
68.00	06800	SPEECH PATHOLOGY	1,398,782	0	1,398,782	0	1,398,782	68.00
69.00	06900	ELECTROCARDIOLOGY	19,772,974		19,772,974	0	19,772,974	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,489,804		2,489,804	0	2,489,804	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,840,735		9,840,735	0	9,840,735	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	193,012,447		193,012,447	0	193,012,447	73.00
74.00	07400	RENAL DIALYSIS	5,899,523		5,899,523	0	5,899,523	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	176,892,239		176,892,239	830,680	177,722,919	90.00
91.00	09100	EMERGENCY	62,508,491		62,508,491	57,211	62,565,702	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	35,777,940		35,777,940		35,777,940	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	1,013,640,652	0	1,013,640,652	3,125,471	1,016,766,123	200.00
201.00		Less Observation Beds	35,777,940		35,777,940		35,777,940	201.00
202.00		Total (see instructions)	977,862,712	0	977,862,712	3,125,471	980,988,183	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet C
Part I
Date/Time Prepared:
6/26/2020 4:52 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	148,562,740		148,562,740			30.00
31.00	03100	INTENSIVE CARE UNIT	25,163,300		25,163,300			31.00
33.00	03300	BURN INTENSIVE CARE UNIT	4,057,900		4,057,900			33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	8,662,300		8,662,300			34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0		0			34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	7,929,800		7,929,800			34.02
34.03	02400	NEURO INTENSIVE CARE	5,547,700		5,547,700			34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	18,884,800		18,884,800			34.04
43.00	04300	NURSERY	1,724,800		1,724,800			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	96,986,556	90,046,108	187,032,664	0.544469	0.000000	50.00
51.00	05100	RECOVERY ROOM	3,335,700	11,849,500	15,185,200	0.517796	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,278,179	5,424	2,283,603	3.423193	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	37,750,773	25,735,546	63,486,319	0.207962	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	44,852,472	139,491,734	184,344,206	0.318030	0.000000	54.00
60.00	06000	LABORATORY	42,459,831	110,582,407	153,042,238	0.419284	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	5,220,015	1,753,793	6,973,808	0.995867	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	7,714,615	3,208,465	10,923,080	1.381685	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,693,136	4,808,028	8,501,164	0.756534	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,590,045	1,835,813	3,425,858	0.770749	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	498,050	1,107,605	1,605,655	0.871160	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	19,847,265	18,331,535	38,178,800	0.517905	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,123,288	3,825,426	11,948,714	0.208374	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,186,773	7,248,155	20,434,928	0.481564	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	78,519,842	125,599,556	204,119,398	0.945586	0.000000	73.00
74.00	07400	RENAL DIALYSIS	4,331,106	5,805,582	10,136,688	0.581997	0.000000	74.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,751,793	122,918,121	124,669,914	1.418885	0.000000	90.00
91.00	09100	EMERGENCY	9,018,012	56,628,402	65,646,414	0.952200	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	17,408,305	31,543,552	48,951,857	0.730880	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	619,099,096	762,324,752	1,381,423,848			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	619,099,096	762,324,752	1,381,423,848			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet C
Part I
Date/Time Prepared:
6/26/2020 4:52 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
33.00	03300	BURN INTENSIVE CARE UNIT			33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT			34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT			34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT			34.02
34.03	02400	NEURO INTENSIVE CARE			34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT			34.04
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.546535		50.00
51.00	05100	RECOVERY ROOM	0.517796		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3.423193		52.00
53.00	05300	ANESTHESIOLOGY	0.210390		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.318760		54.00
60.00	06000	LABORATORY	0.419284		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.995867		62.00
65.00	06500	RESPIRATORY THERAPY	1.381685		65.00
66.00	06600	PHYSICAL THERAPY	0.756534		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.770749		67.00
68.00	06800	SPEECH PATHOLOGY	0.871160		68.00
69.00	06900	ELECTROCARDIOLOGY	0.517905		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.208374		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.481564		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.945586		73.00
74.00	07400	RENAL DIALYSIS	0.581997		74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1.425548		90.00
91.00	09100	EMERGENCY	0.953071		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.730880		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
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: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet C
Part I
Date/Time Prepared:
6/26/2020 4:52 pm

			Title XIX	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Total Costs
			1.00	2.00	3.00	4.00
						5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	142,179,051		142,179,051	1,562,454
31.00	03100	INTENSIVE CARE UNIT	19,944,060		19,944,060	19,944,060
33.00	03300	BURN INTENSIVE CARE UNIT	9,477,121		9,477,121	9,477,121
34.00	03400	SURGICAL INTENSIVE CARE UNIT	8,860,334		8,860,334	8,860,334
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0		0	0
34.02	02180	TRAUMA INTENSIVE CARE UNIT	15,191,248		15,191,248	15,191,248
34.03	02400	NEURO INTENSIVE CARE	5,616,499		5,616,499	5,616,499
34.04	02060	NEONATAL INTENSIVE CARE UNIT	14,322,273		14,322,273	14,322,273
43.00	04300	NURSERY	5,836,617		5,836,617	5,836,617
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	101,833,427		101,833,427	386,430
51.00	05100	RECOVERY ROOM	7,862,839		7,862,839	7,862,839
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,817,213		7,817,213	7,817,213
53.00	05300	ANESTHESIOLOGY	13,202,771		13,202,771	154,126
54.00	05400	RADIOLOGY-DIAGNOSTIC	58,626,962		58,626,962	134,570
60.00	06000	LABORATORY	64,168,168		64,168,168	64,168,168
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	6,944,988		6,944,988	6,944,988
65.00	06500	RESPIRATORY THERAPY	15,092,251	0	15,092,251	15,092,251
66.00	06600	PHYSICAL THERAPY	6,431,419	0	6,431,419	6,431,419
67.00	06700	OCCUPATIONAL THERAPY	2,640,476	0	2,640,476	2,640,476
68.00	06800	SPEECH PATHOLOGY	1,398,782	0	1,398,782	1,398,782
69.00	06900	ELECTROCARDIOLOGY	19,772,974		19,772,974	19,772,974
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,489,804		2,489,804	2,489,804
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,840,735		9,840,735	9,840,735
73.00	07300	DRUGS CHARGED TO PATIENTS	193,012,447		193,012,447	193,012,447
74.00	07400	RENAL DIALYSIS	5,899,523		5,899,523	5,899,523
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	176,892,239		176,892,239	830,680
91.00	09100	EMERGENCY	62,508,491		62,508,491	57,211
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	35,777,940		35,777,940	35,777,940
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				
200.00		Subtotal (see instructions)	1,013,640,652	0	1,013,640,652	3,125,471
201.00		Less Observation Beds	35,777,940		35,777,940	35,777,940
202.00		Total (see instructions)	977,862,712	0	977,862,712	3,125,471

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet C
Part I
Date/Time Prepared:
6/26/2020 4:52 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	148,562,740		148,562,740			30.00	
31.00	03100	INTENSIVE CARE UNIT	25,163,300		25,163,300			31.00	
33.00	03300	BURN INTENSIVE CARE UNIT	4,057,900		4,057,900			33.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	8,662,300		8,662,300			34.00	
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0		0			34.01	
34.02	02180	TRAUMA INTENSIVE CARE UNIT	7,929,800		7,929,800			34.02	
34.03	02400	NEURO INTENSIVE CARE	5,547,700		5,547,700			34.03	
34.04	02060	NEONATAL INTENSIVE CARE UNIT	18,884,800		18,884,800			34.04	
43.00	04300	NURSERY	1,724,800		1,724,800			43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	96,986,556	90,046,108	187,032,664	0.544469	0.000000	50.00	
51.00	05100	RECOVERY ROOM	3,335,700	11,849,500	15,185,200	0.517796	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,278,179	5,424	2,283,603	3.423193	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	37,750,773	25,735,546	63,486,319	0.207962	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	44,852,472	139,491,734	184,344,206	0.318030	0.000000	54.00	
60.00	06000	LABORATORY	42,459,831	110,582,407	153,042,238	0.419284	0.000000	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	5,220,015	1,753,793	6,973,808	0.995867	0.000000	62.00	
65.00	06500	RESPIRATORY THERAPY	7,714,615	3,208,465	10,923,080	1.381685	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	3,693,136	4,808,028	8,501,164	0.756534	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	1,590,045	1,835,813	3,425,858	0.770749	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	498,050	1,107,605	1,605,655	0.871160	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	19,847,265	18,331,535	38,178,800	0.517905	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,123,288	3,825,426	11,948,714	0.208374	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,186,773	7,248,155	20,434,928	0.481564	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	78,519,842	125,599,556	204,119,398	0.945586	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	4,331,106	5,805,582	10,136,688	0.581997	0.000000	74.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,751,793	122,918,121	124,669,914	1.418885	0.000000	90.00	
91.00	09100	EMERGENCY	9,018,012	56,628,402	65,646,414	0.952200	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	17,408,305	31,543,552	48,951,857	0.730880	0.000000	92.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	619,099,096	762,324,752	1,381,423,848			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	619,099,096	762,324,752	1,381,423,848			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet C
Part I
Date/Time Prepared:
6/26/2020 4:52 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
33.00	03300	BURN INTENSIVE CARE UNIT			33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT			34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT			34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT			34.02
34.03	02400	NEURO INTENSIVE CARE			34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT			34.04
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
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
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
OUTPATIENT SERVICE COST CENTERS					
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
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
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: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet D
Part I
Date/Time Prepared:
6/26/2020 4:52 pm

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Hospital Total Patient Days	PPS 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	21,474,677	0	21,474,677	83,996	255.66	30.00
31.00	INTENSIVE CARE UNIT	1,957,698		1,957,698	8,255	237.15	31.00
33.00	BURN INTENSIVE CARE UNIT	619,680		619,680	1,328	466.63	33.00
34.00	SURGICAL INTENSIVE CARE UNIT	752,497		752,497	2,838	265.15	34.00
34.01	PEDIATRIC INTENSIVE CARE UNIT	0		0	0	0.00	34.01
34.02	TRAUMA INTENSIVE CARE UNIT	1,953,470		1,953,470	2,175	898.15	34.02
34.03	NEURO INTENSIVE CARE	412,892		412,892	1,842	224.15	34.03
34.04	NEONATAL INTENSIVE CARE UNIT	1,100,345		1,100,345	6,753	162.94	34.04
43.00	NURSERY	586,071		586,071	1,936	302.72	43.00
200.00	Total (lines 30 through 199)	28,857,330		28,857,330	109,123		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	7,649	1,955,543				30.00
31.00	INTENSIVE CARE UNIT	1,092	258,968				31.00
33.00	BURN INTENSIVE CARE UNIT	172	80,260				33.00
34.00	SURGICAL INTENSIVE CARE UNIT	312	82,727				34.00
34.01	PEDIATRIC INTENSIVE CARE UNIT	0	0				34.01
34.02	TRAUMA INTENSIVE CARE UNIT	245	220,047				34.02
34.03	NEURO INTENSIVE CARE	165	36,985				34.03
34.04	NEONATAL INTENSIVE CARE UNIT	0	0				34.04
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	9,635	2,634,530				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet D
Part II
Date/Time Prepared:
6/26/2020 4:52 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	11,440,689	187,032,664	0.061169	9,382,203	573,900
51.00	05100	RECOVERY ROOM	890,778	15,185,200	0.058661	461,100	27,049
52.00	05200	DELIVERY ROOM & LABOR ROOM	878,592	2,283,603	0.384739	0	0
53.00	05300	ANESTHESIOLOGY	1,542,437	63,486,319	0.024296	3,373,840	81,971
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,894,674	184,344,206	0.037401	4,086,487	152,839
60.00	06000	LABORATORY	6,368,657	153,042,238	0.041614	4,696,120	195,424
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	428,779	6,973,808	0.061484	471,653	28,999
65.00	06500	RESPIRATORY THERAPY	1,643,616	10,923,080	0.150472	1,711,246	257,495
66.00	06600	PHYSICAL THERAPY	449,263	8,501,164	0.052847	487,127	25,743
67.00	06700	OCCUPATIONAL THERAPY	285,541	3,425,858	0.083349	185,130	15,430
68.00	06800	SPEECH PATHOLOGY	156,054	1,605,655	0.097190	72,181	7,015
69.00	06900	ELECTROCARDIOLOGY	2,796,111	38,178,800	0.073237	2,342,241	171,539
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	91,703	11,948,714	0.007675	1,259,833	9,669
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	336,982	20,434,928	0.016490	980,753	16,173
73.00	07300	DRUGS CHARGED TO PATIENTS	11,534,162	204,119,398	0.056507	7,011,636	396,207
74.00	07400	RENAL DIALYSIS	346,948	10,136,688	0.034227	600,762	20,562
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	16,628,144	124,669,914	0.133377	931,238	124,206
91.00	09100	EMERGENCY	5,659,938	65,646,414	0.086219	1,041,040	89,757
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5,345,153	48,951,857	0.109192	2,117,169	231,178
200.00		Total (lines 50 through 199)	73,718,221	1,160,890,508		41,211,759	2,425,156

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet D
Part III
Date/Time Prepared:
6/26/2020 4:52 pm

Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	PPS
			1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	0	0	0	0	0	34.02
34.03	02400	NEURO INTENSIVE CARE	0	0	0	0	0	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	34.04
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of 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	83,996	0.00	7,649	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	8,255	0.00	1,092	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	1,328	0.00	172	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	2,838	0.00	312	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0.00	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	0	0	2,175	0.00	245	34.02
34.03	02400	NEURO INTENSIVE CARE	0	0	1,842	0.00	165	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	0	0	6,753	0.00	0	34.04
43.00	04300	NURSERY	0	0	1,936	0.00	0	43.00
200.00		Total (lines 30 through 199)	0	0	109,123		9,635	200.00
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost				
			9.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0				30.00
31.00	03100	INTENSIVE CARE UNIT	0	0				31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0				33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0				34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0				34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	0	0				34.02
34.03	02400	NEURO INTENSIVE CARE	0	0				34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	0	0				34.04
43.00	04300	NURSERY	0	0				43.00
200.00		Total (lines 30 through 199)	0	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet D
Part IV
Date/Time Prepared:
6/26/2020 4:52 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	389,729	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	389,729	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet D
Part IV
Date/Time Prepared:
6/26/2020 4:52 pm

				Title XVIII		Hospital	PPS		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
			4.00	5.00	6.00	7.00	8.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	187,032,664	0.000000	50.00	
51.00	05100	RECOVERY ROOM	0	0	0	15,185,200	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,283,603	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	63,486,319	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	184,344,206	0.000000	54.00	
60.00	06000	LABORATORY	0	0	0	153,042,238	0.000000	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	6,973,808	0.000000	62.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,923,080	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	8,501,164	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,425,858	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,605,655	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	38,178,800	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	11,948,714	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	20,434,928	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	389,729	389,729	204,119,398	0.001909	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	10,136,688	0.000000	74.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	124,669,914	0.000000	90.00	
91.00	09100	EMERGENCY	0	0	0	65,646,414	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	48,951,857	0.000000	92.00	
200.00		Total (lines 50 through 199)	0	389,729	389,729	1,160,890,508		200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet D
Part IV
Date/Time Prepared:
6/26/2020 4:52 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	9,382,203	0	3,096,135	0
51.00	05100	RECOVERY ROOM	0.000000	461,100	0	695,450	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0.000000	3,373,840	0	1,218,936	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	4,086,487	0	11,849,610	0
60.00	06000	LABORATORY	0.000000	4,696,120	0	6,433,530	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	471,653	0	87,176	0
65.00	06500	RESPIRATORY THERAPY	0.000000	1,711,246	0	218,621	0
66.00	06600	PHYSICAL THERAPY	0.000000	487,127	0	14,720	0
67.00	06700	OCCUPATIONAL THERAPY	0.000000	185,130	0	1,552	0
68.00	06800	SPEECH PATHOLOGY	0.000000	72,181	0	105,887	0
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,342,241	0	1,642,913	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,259,833	0	268,955	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	980,753	0	395,242	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.001909	7,011,636	13,385	20,221,109	38,602
74.00	07400	RENAL DIALYSIS	0.000000	600,762	0	64,224	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	931,238	0	18,365,866	0
91.00	09100	EMERGENCY	0.000000	1,041,040	0	2,830,854	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	2,117,169	0	2,771,504	0
200.00		Total (lines 50 through 199)		41,211,759	13,385	70,282,284	38,602

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet D
Part IV
Date/Time Prepared:
6/26/2020 4:52 pm

				Title XVIII	Hospital	PPS
Cost Center Description			PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
			21.00	24.00		
	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
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
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	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
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
200.00		Total (lines 50 through 199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet D
Part V
Date/Time Prepared:
6/26/2020 4:52 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	0.544469	3,096,135	0	0	1,685,750	50.00
51.00	05100	RECOVERY ROOM	0.517796	695,450	0	0	360,101	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3.423193	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.207962	1,218,936	0	0	253,492	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.318030	11,849,610	0	0	3,768,531	54.00
60.00	06000	LABORATORY	0.419284	6,433,530	0	0	2,697,476	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.995867	87,176	0	0	86,816	62.00
65.00	06500	RESPIRATORY THERAPY	1.381685	218,621	0	0	302,065	65.00
66.00	06600	PHYSICAL THERAPY	0.756534	14,720	0	0	11,136	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.770749	1,552	0	0	1,196	67.00
68.00	06800	SPEECH PATHOLOGY	0.871160	105,887	0	0	92,245	68.00
69.00	06900	ELECTROCARDIOLOGY	0.517905	1,642,913	0	0	850,873	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.208374	268,955	0	0	56,043	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.481564	395,242	0	0	190,334	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.945586	20,221,109	61,145	821,410	19,120,798	73.00
74.00	07400	RENAL DIALYSIS	0.581997	64,224	0	0	37,378	74.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1.418885	18,365,866	0	0	26,059,052	90.00
91.00	09100	EMERGENCY	0.952200	2,830,854	0	0	2,695,539	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.730880	2,771,504	0	0	2,025,637	92.00
200.00		Subtotal (see instructions)		70,282,284	61,145	821,410	60,294,462	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		70,282,284	61,145	821,410	60,294,462	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet D
Part V
Date/Time Prepared:
6/26/2020 4:52 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
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
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	57,818	776,714		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
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
200.00		Subtotal (see instructions)	57,818	776,714		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	57,818	776,714		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet D
Part V
Date/Time Prepared:
6/26/2020 4:52 pm

			Title XIX	Hospital	Cost			
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges PPS Reimbursed Services (see inst.) Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.544469	0	1,214,825	0	0	50.00
51.00	05100	RECOVERY ROOM	0.517796	0	830,576	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3.423193	0	5,424	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.207962	0	2,258,048	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.318030	0	4,122,860	0	0	54.00
60.00	06000	LABORATORY	0.419284	0	2,447,285	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.995867	0	59,094	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1.381685	0	2,989,844	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.756534	0	25,137	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.770749	0	5,178	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.871160	0	11,693	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.517905	0	698,431	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.208374	0	274,051	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.481564	0	664,321	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.945586	0	2,075,356	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.581997	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1.418885	0	5,895,627	0	0	90.00
91.00	09100	EMERGENCY	0.952200	0	5,883,032	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.730880	0	2,920,701	0	0	92.00
200.00		Subtotal (see instructions)		0	32,381,483	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	32,381,483	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet D
Part V
Date/Time Prepared:
6/26/2020 4:52 pm

			Title XIX		Hospital	Cost
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	661,435	0		50.00
51.00	05100	RECOVERY ROOM	430,069	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,567	0		52.00
53.00	05300	ANESTHESIOLOGY	469,588	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,311,193	0		54.00
60.00	06000	LABORATORY	1,026,107	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	58,850	0		62.00
65.00	06500	RESPIRATORY THERAPY	4,131,023	0		65.00
66.00	06600	PHYSICAL THERAPY	19,017	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	3,991	0		67.00
68.00	06800	SPEECH PATHOLOGY	10,186	0		68.00
69.00	06900	ELECTROCARDIOLOGY	361,721	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	57,105	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	319,913	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,962,428	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	8,365,217	0		90.00
91.00	09100	EMERGENCY	5,601,823	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,134,682	0		92.00
200.00		Subtotal (see instructions)	26,942,915	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	26,942,915	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0124	Period: From 12/01/2018 To 11/30/2019	Worksheet D-1 Date/Time Prepared: 6/26/2020 4:52 pm
Cost Center Description		Title XVIII	Hospital	PPS
PART I - ALL PROVIDER COMPONENTS				1.00
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			83,996 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			83,996 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)			63,089 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)			7,649 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)			143,741,505 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)			143,741,505 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)			143,741,505 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,711.29 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			13,089,657 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)			13,089,657 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0124

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

Worksheet D-1

Date/Time Prepared:
6/26/2020 4:52 pm

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	19,944,060	8,255	2,416.00	1,092	2,638,272	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT	9,477,121	1,328	7,136.39	172	1,227,459	45.00
46.00	SURGICAL INTENSIVE CARE UNIT	8,860,334	2,838	3,122.03	312	974,073	46.00
46.01	PEDIATRIC INTENSIVE CARE UNIT	0	0	0.00	0	0	46.01
46.02	TRAUMA INTENSIVE CARE UNIT	15,191,248	2,175	6,984.48	245	1,711,198	46.02
46.03	NEURO INTENSIVE CARE	5,616,499	1,842	3,049.13	165	503,106	46.03
46.04	NEONATAL INTENSIVE CARE UNIT	14,322,273	6,753	2,120.88	0	0	46.04
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					25,550,823	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					45,694,588	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					2,634,530	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,438,541	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					5,073,071	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					40,621,517	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					20,907	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,711.29	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					35,777,940	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0124

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

Worksheet D-1

Date/Time Prepared:
6/26/2020 4:52 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	21,474,677	143,741,505	0.149398	35,777,940	5,345,153	90.00
91.00	Nursing School cost	0	143,741,505	0.000000	35,777,940	0	91.00
92.00	Allied health cost	0	143,741,505	0.000000	35,777,940	0	92.00
93.00	All other Medical Education	0	143,741,505	0.000000	35,777,940	0	93.00

DRAFT

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0124	Period: From 12/01/2018 To 11/30/2019	Worksheet D-1 Date/Time Prepared: 6/26/2020 4:52 pm
Cost Center Description		Title XIX	Hospital	Cost
PART I - ALL PROVIDER COMPONENTS				1.00
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			83,996 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			83,996 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)			63,089 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)			9,045 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)			1,936 15.00
16.00	Nursery days (title V or XIX only)			495 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)			142,179,051 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)			142,179,051 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)			142,179,051 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,692.69 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			15,310,381 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)			15,310,381 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0124

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

Worksheet D-1

Date/Time Prepared:
6/26/2020 4:52 pm

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	5,836,617	1,936	3,014.78	495	1,492,316	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	19,944,060	8,255	2,416.00	1,390	3,358,240	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT	9,477,121	1,328	7,136.39	114	813,548	45.00
46.00	SURGICAL INTENSIVE CARE UNIT	8,860,334	2,838	3,122.03	307	958,463	46.00
46.01	PEDIATRIC INTENSIVE CARE UNIT	0	0	0.00	0	0	46.01
46.02	TRAUMA INTENSIVE CARE UNIT	15,191,248	2,175	6,984.48	356	2,486,475	46.02
46.03	NEURO INTENSIVE CARE	5,616,499	1,842	3,049.13	235	716,546	46.03
46.04	NEONATAL INTENSIVE CARE UNIT	14,322,273	6,753	2,120.88	1,791	3,798,496	46.04
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					30,240,097	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					59,174,562	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						0 54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					20,907	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,692.69	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					35,389,070	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0124

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

Worksheet D-1

Date/Time Prepared:
6/26/2020 4:52 pm

Cost Center Description		Title XIX		Hospital		Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	21,474,677	142,179,051	0.151040	35,389,070	5,345,165	90.00
91.00	Nursing School cost	0	142,179,051	0.000000	35,389,070	0	91.00
92.00	Allied health cost	0	142,179,051	0.000000	35,389,070	0	92.00
93.00	All other Medical Education	0	142,179,051	0.000000	35,389,070	0	93.00

DRAFT

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0124	Period: From 12/01/2018 To 11/30/2019	Worksheet D-3 Date/Time Prepared: 6/26/2020 4:52 pm	
Cost Center Description		Title XVIII	Hospital	PPS	
		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	16,351,935		30.00
31.00	03100	INTENSIVE CARE UNIT	3,166,800		31.00
33.00	03300	BURN INTENSIVE CARE UNIT	533,200		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	904,800		34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0		34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	759,500		34.02
34.03	02400	NEURO INTENSIVE CARE	478,500		34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	0		34.04
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	9,382,203	5,127,702	50.00
51.00	05100	RECOVERY ROOM	461,100	238,756	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	3,373,840	709,822	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,086,487	1,302,609	54.00
60.00	06000	LABORATORY	4,696,120	1,969,008	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	471,653	469,704	62.00
65.00	06500	RESPIRATORY THERAPY	1,711,246	2,364,403	65.00
66.00	06600	PHYSICAL THERAPY	487,127	368,528	66.00
67.00	06700	OCCUPATIONAL THERAPY	185,130	142,689	67.00
68.00	06800	SPEECH PATHOLOGY	72,181	62,881	68.00
69.00	06900	ELECTROCARDIOLOGY	2,342,241	1,213,058	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,259,833	262,516	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	980,753	472,295	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,011,636	6,630,105	73.00
74.00	07400	RENAL DIALYSIS	600,762	349,642	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	931,238	1,327,524	90.00
91.00	09100	EMERGENCY	1,041,040	992,185	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,117,169	1,547,396	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)	41,211,759	25,550,823	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)	0		201.00
202.00		Net charges (line 200 minus line 201)	41,211,759		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0124

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

Worksheet D-3

Date/Time Prepared:
6/26/2020 4:52 pm

Cost Center Description		Title XIX	Hospital	Cost	
		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		18,006,768	30.00
31.00	03100	INTENSIVE CARE UNIT		3,226,091	31.00
33.00	03300	BURN INTENSIVE CARE UNIT		397,520	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		980,502	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT		0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT		1,053,236	34.02
34.03	02400	NEURO INTENSIVE CARE		736,572	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT		4,982,624	34.04
43.00	04300	NURSERY		472,026	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.544469	10,538,057	50.00
51.00	05100	RECOVERY ROOM	0.517796	257,555	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3.423193	218,645	52.00
53.00	05300	ANESTHESIOLOGY	0.207962	4,191,520	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.318030	2,265,067	54.00
60.00	06000	LABORATORY	0.419284	5,237,248	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.995867	537,408	62.00
65.00	06500	RESPIRATORY THERAPY	1.381685	3,043,996	65.00
66.00	06600	PHYSICAL THERAPY	0.756534	470,996	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.770749	241,644	67.00
68.00	06800	SPEECH PATHOLOGY	0.871160	65,670	68.00
69.00	06900	ELECTROCARDIOLOGY	0.517905	1,633,127	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.208374	803,869	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.481564	1,468,296	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.945586	10,586,344	73.00
74.00	07400	RENAL DIALYSIS	0.581997	513,792	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1.418885	820,555	90.00
91.00	09100	EMERGENCY	0.952200	17,664	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.730880	1,752,793	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		44,664,246	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		44,664,246	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0124	Period: From 12/01/2018 To 11/30/2019	Worksheet E Part A Date/Time Prepared: 6/26/2020 4:52 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)		13,699,515	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		3,029,001	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)		1,586,196	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		362,026	2.04
3.00	Managed Care Simulated Payments		6,125,659	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		399.72	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)		522.08	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)		36.60	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).		-85.00	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)		400.48	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		461.88	10.00
11.00	FTE count for residents in dental and podiatric programs.		15.36	11.00
12.00	Current year allowable FTE (see instructions)		415.84	12.00
13.00	Total allowable FTE count for the prior year.		415.10	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.		414.86	14.00
15.00	Sum of lines 12 through 14 divided by 3.		415.27	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		415.27	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		1.038902	19.00
20.00	Prior year resident to bed ratio (see instructions)		1.021533	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		1.021533	21.00
22.00	IME payment adjustment (see instructions)		7,449,024	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		2,727,689	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)		61.40	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)		7,449,024	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		2,727,689	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		17.09	30.00
31.00	Percentage of Medicaid patient days (see instructions)		40.52	31.00
32.00	Sum of lines 30 and 31		57.61	32.00
33.00	Allowable disproportionate share percentage (see instructions)		36.74	33.00
34.00	Disproportionate share adjustment (see instructions)		1,536,515	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0124	Period: From 12/01/2018 To 11/30/2019	Worksheet E Part A Date/Time Prepared: 6/26/2020 4:52 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)	52,476,132	61,124,317		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	43,706,163	10,187,407		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	53,893,570			36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0			43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0			46.00
47.00	Subtotal (see instructions)	81,555,847			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)		84,283,536		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,913,124		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).		2,416,928		52.00
53.00	Nursing and Allied Health Managed Care payment		4,145		53.00
54.00	Special add-on payments for new technologies		0		54.00
54.01	Islet isolation add-on payment		0		54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		13,385		58.00
59.00	Total (sum of amounts on lines 49 through 58)		89,631,118		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		89,631,118		61.00
62.00	Deductibles billed to program beneficiaries		1,580,964		62.00
63.00	Coinsurance billed to program beneficiaries		113,146		63.00
64.00	Allowable bad debts (see instructions)		616,297		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		400,593		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		27,548		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		88,337,601		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0		70.50
70.87	Demonstration payment adjustment amount before sequestration		0		70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0		70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		126,003		70.93
70.94	HRR adjustment amount (see instructions)		-61,131		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet E
Part A
Date/Time Prepared:
6/26/2020 4:52 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	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	0	70.97
70.98	Low Volume Payment-3		0	0	70.98
70.99	HAC adjustment amount (see instructions)		0	0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		88,402,473	71.00	
71.01	Sequestration adjustment (see instructions)		1,768,049	71.01	
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	
72.00	Interim payments		72,161,844	72.00	
73.00	Tentative settlement (for contractor use only)		0	73.00	
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		14,472,580	74.00	
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		132,235	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)	1.0096200000	1.0127000000	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)	0.9968	1.0000	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 DSH PAYMENT PERCENTAGE

Provider CCN: 14-0124

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

Worksheet DSH

Date/Time Prepared:
6/26/2020 4:52 pm

		Title XVIII		Hospital		PPS	
		Original .mcrcx Values	Adjusted .mcrcx Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	17.09	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	40.52	0.00			40.52	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	57.61	0.00			40.52	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	Urban				Urban	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	399.72	0.00			399.72	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	36.74	0.00			22.64	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	Yes				No	9.00
10.00	S-2, Line 45	Yes				Yes	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	17.09	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	No				No	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	13,733	0			13,733	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	0	0			0	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	22,437	0			22,437	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	0	0			0	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	36,170	0			36,170	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	88,216	0			88,216	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	1,051	0			1,051	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	89,267	0			89,267	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	40.52	0.00			40.52	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE

Provider CCN: 14-0124

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

Worksheet DSH

Date/Time Prepared:
6/26/2020 4:52 pm

		Title XVIII		Hospital		PPS	
		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	36.74		0.00	True	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	False	29.00
30.00	Line 28 or 29 as applicable		36.74		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		36.74		0.00		31.00
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
DETERMINATION OF PROVIDER TYPE							
32.00	Does the hospital qualify under the Pickle amendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE

Provider CCN: 14-0124

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

Worksheet DSH

Date/Time Prepared:
6/26/2020 4:52 pm

Title XVIII

Hospital

PPS

		Revised	
		Percentage	
		6.00	
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE		
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	22.64	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	0.00	29.00
30.00	Line 28 or 29 as applicable	22.64	30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	22.64	31.00

DRAFT

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
6/26/2020 4:52 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	13,699,515	0	13,699,515		13,699,515
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,029,001	0		3,029,001	3,029,001
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	1,586,196	0	1,586,196		1,586,196
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	362,026	0		362,026	362,026
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	6,125,659	0	5,071,282	1,054,377	6,125,659
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	1,021,533	1,021,533	1,021,533	1,021,533	
6.00	IME payment adjustment (see instructions)	22.00	7,449,024	0	6,100,243	1,348,781	7,449,024
6.01	IME payment adjustment for managed care (see instructions)	22.01	2,727,689	0	2,258,187	469,502	2,727,689
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	7,449,024	0	6,100,243	1,348,781	7,449,024
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	2,727,689	0	2,258,187	469,502	2,727,689
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.3674	0.3674	0.3674	0.3674	
11.00	Disproportionate share adjustment (see instructions)	34.00	1,536,515	0	1,258,301	278,214	1,536,515
11.01	Uncompensated care payments	36.00	53,893,570	0	23,360,962	8,769,969	32,130,931
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	81,555,847	0	67,767,856	13,787,991	81,555,847
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	84,283,536	0	70,026,043	14,257,493	84,283,536
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,913,124	0	2,400,569	512,555	2,913,124

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
6/26/2020 4:52 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0
17.01	Net organ aquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	72,426,612	14,770,048	87,196,660
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	1,356,089	0	1,114,517	241,572	1,356,089
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	674,492	0	560,724	113,768	674,492
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.5270	0.5270	0.5270	0.5270	
23.00	Indirect medical education adjustment (see instructions)	6.00	714,659	0	587,351	127,308	714,659
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1238	0.1238	0.1238	0.1238	
25.00	Disproportionate share adjustment (see instructions)	11.00	167,884	0	137,977	29,907	167,884
26.00	Total prospective capital payments (see instructions)	12.00	2,913,124	0	2,400,569	512,555	2,913,124
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.000000	0.250000	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				3,692,512	3,692,512
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
6/26/2020 4:52 pm

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	13,699,515	13,699,515		13,699,515	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,029,001		3,029,001	3,029,001	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	1,586,196	1,586,196		1,586,196	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	362,026		362,026	362,026	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	6,125,659	5,071,282	1,054,377	6,125,659	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	1,021,533	1,021,533	1,021,533		5.00
6.00	IME payment adjustment (see instructions)	22.00	7,449,024	6,100,243	1,348,781	7,449,024	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	2,727,689	2,258,187	469,502	2,727,689	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	7,449,024	6,100,243	1,348,781	7,449,024	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	2,727,689	2,258,187	469,502	2,727,689	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.3674	0.3674	0.3674		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	1,536,515	1,258,301	278,214	1,536,515	11.00
11.01	Uncompensated care payments	36.00	53,893,570	23,360,962	8,746,039	32,107,001	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	81,555,847	67,791,786	13,764,061	81,555,847	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	84,283,536	70,049,973	14,233,563	84,283,536	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,913,124	2,400,569	512,555	2,913,124	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			72,450,542	14,746,118	87,196,660	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
6/26/2020 4:52 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,356,089	1,114,517	241,572	1,356,089	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	674,492	560,724	113,768	674,492	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.5270	0.5270	0.5270		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	714,659	587,351	127,308	714,659	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1238	0.1238	0.1238		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	167,884	137,977	29,907	167,884	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2,913,124	2,400,569	512,555	2,913,124	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	126,003	109,169	16,834	126,003	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-61,131	-49,318	-11,813	-61,131	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.						100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0124	Period: From 12/01/2018 To 11/30/2019	Worksheet E Part B Date/Time Prepared: 6/26/2020 4:52 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		834,532	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		60,255,860	2.00
3.00	OPPS payments		23,677,160	3.00
4.00	Outlier payment (see instructions)		1,800,420	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		38,602	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		834,532	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		882,555	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)		882,555	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)		882,555	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		48,023	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)		834,532	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)		25,516,182	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		5,252,980	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)		21,097,734	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		3,233,308	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)		24,331,042	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		24,331,042	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)		2,686,429	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		1,746,179	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		352,488	36.00
37.00	Subtotal (see instructions)		26,077,221	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		26,077,221	40.00
40.01	Sequestration adjustment (see instructions)		521,544	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		25,955,956	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-400,279	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet E
Part B
Date/Time Prepared:
6/26/2020 4:52 pm

Title XVIII

Hospital

PPS

Overrides

1.00

WORKSHEET OVERRIDE VALUES

112.00 Override of Ancillary service charges (line 12)

0 112.00

DRAFT

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet E-1
Part I
Date/Time Prepared:
6/26/2020 4:52 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		71,695,987		25,602,394	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	11/25/2019	415,877	11/25/2019	99,929	3.01	
3.02		02/28/2019	49,980	02/28/2019	253,633	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)		465,857		353,562	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)		72,161,844		25,955,956	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		14,472,580		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		400,279	6.02	
7.00	Total Medicare program liability (see instructions)		86,634,424		25,555,677	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: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet E-1
Part II
Date/Time Prepared:
6/26/2020 4:52 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
		Overrides	
		1.00	
CONTRACTOR OVERRIDES			
108.00	Override of HIT payment		108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet E-3
Part VII
Date/Time Prepared:
6/26/2020 4:52 pm

		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		59,174,562		1.00
2.00	Medical and other services			26,942,915	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		59,174,562	26,942,915	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		59,174,562	26,942,915	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		29,855,338		8.00
9.00	Ancillary service charges		44,664,246	32,381,483	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		74,519,584	32,381,483	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		74,519,584	32,381,483	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		15,345,022	5,438,568	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		59,174,562	26,942,915	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0	0	24.00
25.00	Capital exception payments (see instructions)		0	0	25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		59,174,562	26,942,915	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		59,174,562	26,942,915	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		59,174,562	26,942,915	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		59,174,562	26,942,915	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		59,174,562	26,942,915	40.00
41.00	Interim payments		59,174,562	26,942,915	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00
OVERRIDES					
109.00	Override Ancillary service charges (line 9)		0	0	109.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0124		Period: From 12/01/2018 To 11/30/2019	Worksheet E-4 Date/Time Prepared: 6/26/2020 4:52 pm
		Title XVIII		Hospital	PPS
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			526.48	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			65.83	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			-60.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			400.65	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			466.22	6.00
7.00	Enter the lesser of line 5 or line 6			400.65	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	194.08	226.94	421.02	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	166.78	195.02	361.80	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		14.86		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	166.78	209.88		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	172.18	202.91		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	166.68	208.89		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	168.55	207.23		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	168.55	207.23		17.00
18.00	Per resident amount	102,495.99	101,628.18		18.00
19.00	Approved amount for resident costs	17,275,699	21,060,408	38,336,107	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			65.57	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			38,336,107	25.00
		Inpatient Part	Managed care		
		A			
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	9,635	3,769		26.00
27.00	Total Inpatient Days (see instructions)	87,331	87,331		27.00
28.00	Ratio of inpatient days to total inpatient days	0.110327	0.043158		28.00
29.00	Program direct GME amount	4,229,508	1,654,510		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		233,782		30.00
31.00	Net Program direct GME amount			5,650,236	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0124	Period: From 12/01/2018 To 11/30/2019	Worksheet E-4 Date/Time Prepared: 6/26/2020 4:52 pm
		Title XVIII	Hospital	PPS
			1.00	
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		10,136,688	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		881	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		45,694,588	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		45,694,588	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		61,128,994	42.00
43.00	Primary payer payments (see instructions)		0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		61,128,994	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		106,823,582	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.427757	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.572243	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		5,650,236	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		2,416,928	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		3,233,308	50.00

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

Provider CCN: 14-0124

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

Worksheet G

Date/Time Prepared:
6/26/2020 4:52 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	33,322,172	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	73,375,060	0	0	0	4.00
5.00 Other receivable	159,340,548	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00 Inventory	7,391,802	0	0	0	7.00
8.00 Prepaid expenses	0	0	0	0	8.00
9.00 Other current assets	836,845,117	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)	1,110,274,699	0	0	0	11.00
FIXED ASSETS					
12.00 Land	990,911	0	0	0	12.00
13.00 Land improvements	2,631,393	0	0	0	13.00
14.00 Accumulated depreciation	-2,105,744	0	0	0	14.00
15.00 Buildings	800,847,880	0	0	0	15.00
16.00 Accumulated depreciation	-346,318,251	0	0	0	16.00
17.00 Leasehold improvements	0	0	0	0	17.00
18.00 Accumulated depreciation	0	0	0	0	18.00
19.00 Fixed equipment	13,729,987	0	0	0	19.00
20.00 Accumulated depreciation	-11,431,650	0	0	0	20.00
21.00 Automobiles and trucks	0	0	0	0	21.00
22.00 Accumulated depreciation	0	0	0	0	22.00
23.00 Major movable equipment	170,520,803	0	0	0	23.00
24.00 Accumulated depreciation	-146,268,939	0	0	0	24.00
25.00 Minor equipment depreciable	0	0	0	0	25.00
26.00 Accumulated depreciation	0	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)	482,596,390	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	0	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	1,592,871,089	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	66,054,444	0	0	0	37.00
38.00 Salaries, wages, and fees payable	45,245,614	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	0	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	1,262,962	0	0	0	43.00
44.00 Other current liabilities	5,500,990	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	118,064,010	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	0	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	0	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	118,064,010	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	1,474,807,079	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)	1,474,807,079	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	1,592,871,089	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0124

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

Worksheet G-1

Date/Time Prepared:
6/26/2020 4:52 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		1,488,172,916		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-67,865,799				2.00
3.00	Total (sum of line 1 and line 2)		1,420,307,117		0		3.00
4.00	OTHER	54,499,965		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)		54,499,965		0		10.00
11.00	Subtotal (line 3 plus line 10)		1,474,807,082		0		11.00
12.00	ROUNDING	3		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)		3		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		1,474,807,079		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	OTHER		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	ROUNDING		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0124

Period:
From 12/01/2018
To 11/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
6/26/2020 4:52 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	144,197,472		144,197,472	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				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)	144,197,472		144,197,472	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	24,978,586		24,978,586	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT	4,138,100		4,138,100	13.00
14.00	SURGICAL INTENSIVE CARE UNIT	8,708,232		8,708,232	14.00
14.01	PEDIATRIC INTENSIVE CARE UNIT	3,795,992		3,795,992	14.01
14.02	TRAUMA INTENSIVE CARE UNIT	7,046,088		7,046,088	14.02
14.03	NEURO INTENSIVE CARE	5,627,104		5,627,104	14.03
14.04	NEONATAL INTENSIVE CARE UNIT	18,834,300		18,834,300	14.04
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	73,128,402		73,128,402	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	217,325,874		217,325,874	17.00
18.00	Ancillary services	400,211,863	412,409,958	812,621,821	18.00
19.00	Outpatient services	13,866,167	512,782,933	526,649,100	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	Other Patient Service Revenue	51,883,603	47,659,525	99,543,128	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	683,287,507	972,852,416	1,656,139,923	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		957,383,054		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)		957,383,054		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0124

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

Worksheet G-3

Date/Time Prepared:
6/26/2020 4:52 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,656,139,923	1.00
2.00	Less contractual allowances and discounts on patients' accounts	894,313,586	2.00
3.00	Net patient revenues (line 1 minus line 2)	761,826,337	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	957,383,054	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-195,556,717	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	440,802	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	0	24.00
24.01	Misc Income	14,104,472	24.01
24.02	Revenue from county	1,853,462	24.02
24.03	EHR Incentive Revenue	2,098,465	24.03
24.04	Graduate Medical Education	109,193,717	24.04
25.00	Total other income (sum of lines 6-24)	127,690,918	25.00
26.00	Total (line 5 plus line 25)	-67,865,799	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)	-67,865,799	29.00

ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

 Provider CCN: 14-0124
 Component CCN: 14-2313

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

 Worksheet I-1
 Date/Time Prepared:
 6/26/2020 4:52 pm

		Renal Dialysis			
		Total Costs	Basis	Statistics	FTEs per 2080 Hours
		1.00	2.00	3.00	4.00
1.00	REGISTERED NURSES	873,923	HOURS OF SERVICE	17,669.00	8.49
2.00	LICENSED PRACTICAL NURSES	0	HOURS OF SERVICE	0.00	0.00
3.00	NURSES AIDES	65,434	HOURS OF SERVICE	2,831.00	1.36
4.00	TECHNICIANS	273,384	HOURS OF SERVICE	10,494.00	5.05
5.00	SOCIAL WORKERS	0	HOURS OF SERVICE	0.00	0.00
6.00	DIETICIANS	0	HOURS OF SERVICE	0.00	0.00
7.00	PHYSICIANS	865,219	ACCUMULATED COST		7.00
8.00	NON-PATIENT CARE SALARY	322,700	ACCUMULATED COST		8.00
9.00	SUBTOTAL (SUM OF LINES 1-8)	2,400,660			9.00
10.00	EMPLOYEE BENEFITS	0	SALARY		10.00
11.00	CAPITAL RELATED COSTS-BLDGS. & FIXTURES	0	SQUARE FEET		11.00
12.00	CAPITAL RELATED COSTS-MOV. EQUIP.	0	PERCENTAGE OF TIME		12.00
13.00	MACHINE COSTS & REPAIRS	0	PERCENTAGE OF TIME		13.00
14.00	SUPPLIES	7,308	REQUISITIONS		14.00
15.00	DRUGS	0	REQUISITIONS		15.00
16.00	OTHER	165,680	ACCUMULATED COST		16.00
17.00	SUBTOTAL (SUM OF LINES 9-16)*	2,573,648			17.00
18.00	CAPITAL RELATED COSTS-BLDGS. & FIXTURES	54,408	SQUARE FEET		18.00
19.00	CAPITAL RELATED COSTS-MOV. EQUIP.	20,803	PERCENTAGE OF TIME		19.00
20.00	EMPLOYEE BENEFITS DEPARTMENT	1,278,398	SALARY		20.00
21.00	ADMINISTRATIVE & GENERAL	1,378,228	ACCUMULATED COST		21.00
22.00	MAINT./REPAIRS-OPER-HOUSEKEEPING	218,232	SQUARE FEET		22.00
23.00	MEDICAL EDUCATION PROGRAM COSTS	0			23.00
24.00	CENTRAL SERVICE & SUPPLIES	0	REQUISITIONS		24.00
25.00	PHARMACY	0	REQUISITIONS		25.00
26.00	OTHER ALLOCATED COSTS	375,806	ACCUMULATED COST		26.00
27.00	SUBTOTAL (SUM OF LINES 17-26)*	5,899,523			27.00
28.00	LABORATORY (SEE INSTRUCTIONS)	0	CHARGES	0	28.00
29.00	RESPIRATORY THERAPY (SEE INSTRUCTIONS)	0	CHARGES	0	29.00
30.00	OTHER ANCILLARY SERVICE COST CENTERS	0	CHARGES	0	30.00
31.00	TOTAL COSTS (SUM OF LINES 27-30)	5,899,523			31.00

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES

Provider CCN: 14-0124

Period:

Worksheet I-2

Component CCN: 14-2313

From 12/01/2018
To 11/30/2019Date/Time Prepared:
6/26/2020 4:52 pm

Renal Dialysis

		Capital Related Costs		Direct Patient Care Salary		Employee Benefits Department	Drugs	
		Building	Equipment	RNs	Other			
		1.00	2.00	3.00	4.00	5.00	6.00	
1.00	Total Renal Department Costs	272,640	20,803	873,923	338,818	1,278,398	0	1.00
MAINTENANCE								
2.00	Hemodialysis	153,894	11,742	493,294	191,249	721,604	0	2.00
2.01	AKI-Hemodialysis	0	0	0	0	0	0	2.01
3.00	Intermittent Peritoneal	0	0	0	0	0	0	3.00
3.01	AKI-Intermittent Peritoneal	0	0	0	0	0	0	3.01
TRAINING								
4.00	Hemodialysis	0	0	0	0	0	0	4.00
5.00	Intermittent Peritoneal	0	0	0	0	0	0	5.00
6.00	CAPD	0	0	0	0	0	0	6.00
7.00	CCPD	0	0	0	0	0	0	7.00
HOME								
8.00	Hemodialysis	0	0	0	0	0	0	8.00
9.00	Intermittent Peritoneal	0	0	0	0	0	0	9.00
10.00	CAPD	0	0	0	0	0	0	10.00
11.00	CCPD	0	0	0	0	0	0	11.00
OTHER BILLABLE SERVICES								
12.00	Inpatient Dialysis	118,746	9,061	380,629	147,569	556,794	0	12.00
13.00	Method II Home Patient	0	0	0	0	0	0	13.00
14.00	ESAs (included in Renal Department)	0	0	0	0	0	0	14.00
15.00								15.00
16.00	Other	0	0	0	0	0	0	16.00
17.00	Total (sum of lines 2 through 16)	272,640	20,803	873,923	338,818	1,278,398	0	17.00
18.00	Medical Educational Program Costs							18.00
19.00	Total Renal Costs (line 17 + line 18)							19.00
		Medical Supplies	Routine Ancillary Services	Subtotal (sum of cols. 1-8)	Overhead	Total (col. 9 + col. 10)		
		7.00	8.00	9.00	10.00	11.00		
1.00	Total Renal Department Costs	7,308	0	2,791,890	3,107,633	5,899,523		1.00
MAINTENANCE								
2.00	Hemodialysis	4,125	0	1,575,908	1,754,132	3,330,040		2.00
2.01	AKI-Hemodialysis	0	0	0	0	0		2.01
3.00	Intermittent Peritoneal	0	0	0	0	0		3.00
3.01	AKI-Intermittent Peritoneal	0	0	0	0	0		3.01
TRAINING								
4.00	Hemodialysis	0	0	0	0	0		4.00
5.00	Intermittent Peritoneal	0	0	0	0	0		5.00
6.00	CAPD	0	0	0	0	0		6.00
7.00	CCPD	0	0	0	0	0		7.00
HOME								
8.00	Hemodialysis	0	0	0	0	0		8.00
9.00	Intermittent Peritoneal	0	0	0	0	0		9.00
10.00	CAPD	0	0	0	0	0		10.00
11.00	CCPD	0	0	0	0	0		11.00
OTHER BILLABLE SERVICES								
12.00	Inpatient Dialysis	3,183	0	1,215,982	1,353,501	2,569,483		12.00
13.00	Method II Home Patient	0	0	0	0	0		13.00
14.00	ESAs (included in Renal Department)							14.00
15.00								15.00
16.00	Other	0	0	0	0	0		16.00
17.00	Total (sum of lines 2 through 16)	7,308	0	2,791,890	3,107,633	5,899,523		17.00
18.00	Medical Educational Program Costs					0		18.00
19.00	Total Renal Costs (line 17 + line 18)					5,899,523		19.00

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0124
Component CCN: 14-2313Period:
From 12/01/2018
To 11/30/2019Worksheet I-3
Date/Time Prepared:
6/26/2020 4:52 pm

		Capital Related Costs		Direct Patient Care Salary		Renal Dialysis	
		Building (Square Feet)	Equipment (% of Time)	RNs (Hours)	Other (Hours)	Employee Benefits Department (Salary)	
	0	1.00	2.00	3.00	4.00	5.00	
1.00	Total Renal Department Costs	272,640	20,803	873,923	338,818	1,278,398	1.00
MAINTENANCE							
2.00	Hemodialysis	3,529	3,529.00	3,529.00	3,529.00	3,529	2.00
2.01	AKI-Hemodialysis	0	0.00	0.00	0.00	0	2.01
3.00	Intermittent Peritoneal	0	0.00	0.00	0.00	0	3.00
3.01	AKI-Intermittent Peritoneal	0	0.00	0.00	0.00	0	3.01
TRAINING							
4.00	Hemodialysis	0	0.00	0.00	0.00	0	4.00
5.00	Intermittent Peritoneal	0	0.00	0.00	0.00	0	5.00
6.00	CAPD	0	0.00	0.00	0.00	0	6.00
7.00	CCPD	0	0.00	0.00	0.00	0	7.00
HOME							
8.00	Hemodialysis	0	0.00	0.00	0.00	0	8.00
9.00	Intermittent Peritoneal	0	0.00	0.00	0.00	0	9.00
10.00	CAPD	0	0.00	0.00	0.00	0	10.00
11.00	CCPD	0	0.00	0.00	0.00	0	11.00
OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis Treatments	2,723	2,723.00	2,723.00	2,723.00	2,723	12.00
13.00	Method II Home Patient	0	0.00	0.00	0.00	0	13.00
14.00	ESAs						14.00
15.00							15.00
16.00	Other	0	0.00	0.00	0.00	0	16.00
17.00	Total Statistical Basis	6,252	6,252.00	6,252.00	6,252.00	6,252	17.00
18.00	Unit Cost Multiplier (line 1 ÷ line 17)	43.608445	3.327415	139.782949	54.193538	204.478247	18.00
		Drugs (Requist.)	Medical Supplies (Requist.)	Routine Ancillary Services (Charges)	Subtotal	Overhead (Accum. Cost)	
	6.00	7.00	8.00	9.00	10.00		
1.00	Total Renal Department Costs	0	7,308	0	2,791,890	3,107,633	1.00
MAINTENANCE							
2.00	Hemodialysis	0	3,529	0			2.00
2.01	AKI-Hemodialysis	0	0	0			2.01
3.00	Intermittent Peritoneal	0	0	0			3.00
3.01	AKI-Intermittent Peritoneal	0	0	0			3.01
TRAINING							
4.00	Hemodialysis	0	0	0			4.00
5.00	Intermittent Peritoneal	0	0	0			5.00
6.00	CAPD	0	0	0			6.00
7.00	CCPD	0	0	0			7.00
HOME							
8.00	Hemodialysis	0	0	0			8.00
9.00	Intermittent Peritoneal	0	0	0			9.00
10.00	CAPD	0	0	0			10.00
11.00	CCPD	0	0	0			11.00
OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis Treatments	0	2,723	0			12.00
13.00	Method II Home Patient	0	0	0			13.00
14.00	ESAs						14.00
15.00							15.00
16.00	Other	0	0	0			16.00
17.00	Total Statistical Basis	0	6,252	0	2,791,890		17.00
18.00	Unit Cost Multiplier (line 1 ÷ line 17)	0.000000	1.168906	0.000000	1.113093		18.00

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

Provider CCN: 14-0124
Component CCN: 14-2313Period:
From 12/01/2018
To 11/30/2019Worksheet I-4
Date/Time Prepared:
6/26/2020 4:52 pm

		Rate 0		Renal Dialysis		
		Number of Total Treatments	Total Cost (from Wkst. I-2, col. 11)	Average Cost of Treatments (col. 2 ÷ col. 1)	Number of Program Treatments	Total Program Expenses (see instructions)
		1.00	2.00	3.00	4.00	5.00
1.00	Maintenance - Hemodialysis	3,701	3,330,040	899.77	83	74,681
2.00	Maintenance - Peritoneal Dialysis	0	0	0.00	0	0
3.00	Training - Hemodialysis	0	0	0.00	0	0
4.00	Training - Peritoneal Dialysis	0	0	0.00	0	0
5.00	Training - CAPD	0	0	0.00	0	0
6.00	Training - CCPD	0	0	0.00	0	0
7.00	Home Program - Hemodialysis	0	0	0.00	0	0
8.00	Home Program - Peritoneal Dialysis	0	0	0.00	0	0
		Patient Weeks			Patient Weeks	
		1.00	2.00	3.00	4.00	5.00
9.00	Home Program - CAPD	0	0	0.00	0	0
10.00	Home Program - CCPD	0	0	0.00	0	0
11.00	Totals (sum of lines 1 through 8, cols. 1 and 4) (sum of lines 1 through 10, cols. 2, 5, and 6) (see instruction)	3,701	3,330,040		83	74,681
12.00	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instruction)	3,701				
		Total Program Payment	Average Payment Rate (col. 6 ÷ col. 4)			
		6.00	7.00			
1.00	Maintenance - Hemodialysis	22,431	270.25			1.00
2.00	Maintenance - Peritoneal Dialysis	0	0.00			2.00
3.00	Training - Hemodialysis	0	0.00			3.00
4.00	Training - Peritoneal Dialysis	0	0.00			4.00
5.00	Training - CAPD	0	0.00			5.00
6.00	Training - CCPD	0	0.00			6.00
7.00	Home Program - Hemodialysis	0	0.00			7.00
8.00	Home Program - Peritoneal Dialysis	0	0.00			8.00
		6.00	7.00			
9.00	Home Program - CAPD	0	0.00			9.00
10.00	Home Program - CCPD	0	0.00			10.00
11.00	Totals (sum of lines 1 through 8, cols. 1 and 4) (sum of lines 1 through 10, cols. 2, 5, and 6) (see instruction)	22,431				11.00
12.00	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instruction)					12.00

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B		Provider CCN: 14-0124	Period: From 12/01/2018 To 11/30/2019	Worksheet I-5 Date/Time Prepared: 6/26/2020 4:52 pm
		1.00	2.00	
PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B				
1.00	Total expenses related to care of program beneficiaries (see instructions)	74,681		1.00
2.00	Total payment due (from Wkst. I-4, col. 6, line 11) (see instructions)	22,431	22,431	2.00
2.01	Total payment due (from Wkst. I-4, col. 6.01, line 11) (see instructions)			2.01
2.02	Total payment due (from Wkst. I-4, col. 6.02, line 11) (see instructions)			2.02
2.03	Total payment due (see instructions)	22,431	22,431	2.03
2.04	Outlier payments	0		2.04
3.00	Deductibles billed to Medicare (Part B) patients (see instructions)	185	185	3.00
3.01	Deductibles billed to Medicare (Part B) patients (see instructions)			3.01
3.02	Deductibles billed to Medicare (Part B) patients (see instructions)			3.02
3.03	Total deductibles billed to Medicare (Part B) patients (see instructions)	185	185	3.03
4.00	Coinsurance billed to Medicare (Part B) patients	4,449	4,449	4.00
4.01	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.01
4.02	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.02
4.03	Total coinsurance billed to Medicare (Part B) patients (see instructions)	4,449	4,449	4.03
5.00	Bad debts for deductibles and coinsurance, net of bad debt recoveries	0	0	5.00
5.01	Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2011 but before 1/1/2012			5.01
5.02	Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013			5.02
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014			5.03
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2014	0	0	5.04
5.05	Allowable bad debts (sum of lines 5 through line 5.04)	0	0	5.05
6.00	Adjusted reimbursable bad debts (see instructions)	0		6.00
7.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		7.00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions)	0	4,634	8.00
9.00	Program payment (see instructions)	0	17,797	9.00
10.00	Unrecovered from Medicare (Part B) patients (see instructions)			10.00
11.00	Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)	0		11.00
PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE				
12.00	Total allowable expenses (see instructions)	3,330,040		12.00
13.00	Total composite costs (from Wkst. I-4, col. 2, line 11)	3,330,040		13.00
14.00	Facility specific composite cost percentage (line 13 divided by line 12)	1.000000		14.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0124	Period: From 12/01/2018 To 11/30/2019	Worksheet L Parts I-III Date/Time Prepared: 6/26/2020 4:52 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,356,089	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		674,492	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)		239.26	3.00
4.00	Number of interns & residents (see instructions)		415.27	4.00
5.00	Indirect medical education percentage (see instructions)		52.70	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)		714,659	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		17.09	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		40.52	8.00
9.00	Sum of lines 7 and 8		57.61	9.00
10.00	Allowable disproportionate share percentage (see instructions)		12.38	10.00
11.00	Disproportionate share adjustment (see instructions)		167,884	11.00
12.00	Total prospective capital payments (see instructions)		2,913,124	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