

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: 14-0300	Period: From 12/01/2018 To 11/30/2019	Worksheet S Parts I-III Date/Time Prepared: 6/26/2020 1:35 pm
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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 PROVIDENT HOSPITAL (14-0300) 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)

Title

Date

		Title XVIII		HIT	Title XIX	
Title V		Part A	Part B			
1.00		2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	1,063,745	213,742	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	0	0	6.00
10.00	RURAL HEALTH CLINIC I	0	0	0	0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	11.00
200.00	Total	0	1,063,745	213,742	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: 14-0300		Period: From 12/01/2018 To 11/30/2019		Worksheet S-2 Part I Date/Time Prepared: 6/26/2020 1:35 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 500 EAST 51ST STREET			PO Box:				1.00	
2.00	City: CHICAGO			State: IL		Zip Code: 60615-		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			PROVIDENT HOSPITAL	140300	16974	1	10/08/1993	N
4.00	Subprovider - IPF							P	O
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								
17.10	Hospital-Based (CORF) I								
18.00	Renal Dialysis								
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)						13		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.			334	0	0	0	603	0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet S-2
Part I
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	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
					Urban/Rural S	Date of Geogr	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	45.00
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	46.00
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	47.00
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	48.00
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					Y		56.00
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N		57.00
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		58.00
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		59.00
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1.00	2.00	3.00	
60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)				N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet S-2
Part I
Date/Time Prepared:
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	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	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

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

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				1.00	
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		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)		N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.		N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
			Physical	Occupational	
			1.00	2.00	
			Speech	Respiratory	
			3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N	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: 14-0300	Period: From 12/01/2018 To 11/30/2019	Worksheet S-2 Part I Date/Time Prepared: 6/26/2020 1:35 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:	0	290,000	179,498	118.01
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N			121.00
122.00	Does the cost report contain 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: 14-0300		Period: From 12/01/2018 To 11/30/2019		Worksheet S-2 Part I Date/Time Prepared: 6/26/2020 1:35 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: NATIONAL GOVERNMENT SERVICES, INC		Contractor's Number: 00131				141.00
142.00	Street: 1340 S. DAMEN AVE, SUITE 215		PO Box:						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
									1.00
									2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				N				145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								146.00
									1.00
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.									N
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.									N
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.									N
				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		
156.00	Subprovider - IPF			N	N	N	N		
157.00	Subprovider - IRF			N	N	N	N		
158.00	SUBPROVIDER								
159.00	SNF			N	N	N	N		
160.00	HOME HEALTH AGENCY			N	N	N	N		
161.00	CMHC				N	N	N		
161.10	CORF				N	N	N		
									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
		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
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)									
168.01 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)									
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
						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)									
									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: 14-0300	Period: From 12/01/2018 To 11/30/2019	Worksheet S-2 Part II Date/Time Prepared: 6/26/2020 2:16 pm
			Y/N 1.00	Date 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 1.00	Date 2.00	V/I 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)	Y		3.00
		Y/N 1.00	Type 2.00	Date 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 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	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.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 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: 14-0300

Period:
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Date/Time Prepared:
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		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.	WADE	HILL		41.00
42.00	Enter the employer/company name of the cost report preparer.	BRADLEY ASSOCIATES			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-237-5500	WADEH@BRADLEYCPA.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0300

Period:
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		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.	PARTNER	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

Health Financial Systems		PROVIDENT HOSPITAL		Non-CMS HFS Worksheet	
HFS Supplemental Information		Provider CCN: 14-0300	Period: From 12/01/2018 To 11/30/2019	Worksheet S-2 Part IX Date/Time Prepared: 6/26/2020 1:35 pm	
			Title V 1.00	Title XIX 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 1.00	Outpatient 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 1.00	Title XIX 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: 14-0300

Period:
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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	25	9,125	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)		25	9,125	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		25	9,125	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
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0300

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Date/Time Prepared:
6/26/2020 1:35 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)	295	334	3,355			1.00
2.00	HMO and other (see instructions)	181	603				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)	295	334	3,355			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	0			13.00
14.00	Total (see instructions)	295	334	3,355	4.08	377.34	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
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				4.08	377.34	27.00
28.00	Observation Bed Days		0	824			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0300

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To 11/30/2019Worksheet S-3
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Date/Time Prepared:
6/26/2020 1:35 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	74	93	538	1.00
2.00 HMO and other (see instructions)			35	113		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	74	93	538	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
25.10 CMHC - CORF	0.00					25.10
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet S-3
Part II
Date/Time Prepared:
6/26/2020 1:35 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	32,879,606	3,161,621	36,041,227	784,858.00	45.92
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		1,253,348	0	1,253,348	9,356.00	133.96
4.01	Physicians - Part A - Teaching		891,862	0	891,862	6,478.00	137.68
5.00	Physician and Non Physician-Part B		7,990,832	0	7,990,832	63,573.00	125.70
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	13,184	13,184	165.00	79.90
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		480,346	0	480,346	7,543.00	63.68
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		3,405,869	0	3,405,869	78,268.00	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)		7,419,001	0	7,419,001		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		0	0	0		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		352,668	0	352,668		
22.01	Physician Part A - Teaching		250,907	0	250,907		
23.00	Physician Part B		2,249,460	0	2,249,460		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		3,727	0	3,727		
25.50	Home office wage-related (core)		744,460	0	744,460		
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	79,806	0	79,806	2,081.00	38.35
27.00	Administrative & General	5.00	2,192,912	0	2,192,912	72,002.00	30.46

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HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet S-3
Part II
Date/Time Prepared:
6/26/2020 1:35 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.)		43,365	0	43,365	819.00	52.95	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,284,356	0	2,284,356	44,323.00	51.54	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,149,267	0	1,149,267	51,956.00	22.12	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		131,439	0	131,439	5,715.00	23.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,024,265	0	1,024,265	18,759.00	54.60	38.00
39.00	Central Services and Supply	14.00	250,012	0	250,012	10,367.00	24.12	39.00
40.00	Pharmacy	15.00	2,790,858	0	2,790,858	57,538.00	48.50	40.00
41.00	Medical Records & Medical Records Library	16.00	147,723	0	147,723	6,009.00	24.58	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet S-3
Part III
Date/Time Prepared:
6/26/2020 1:35 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)	24,171,716	3,148,437	27,320,153	721,176.00	37.88	1.00
2.00	Excluded area salaries (see instructions)	0	0	0	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)	24,171,716	3,148,437	27,320,153	721,176.00	37.88	3.00
4.00	Subtotal other wages & related costs (see inst.)	3,886,215	0	3,886,215	85,811.00	45.29	4.00
5.00	Subtotal wage-related costs (see inst.)	8,516,129	0	8,516,129	0.00	31.17	5.00
6.00	Total (sum of lines 3 thru 5)	36,574,060	3,148,437	39,722,497	806,987.00	49.22	6.00
7.00	Total overhead cost (see instructions)	10,094,003	0	10,094,003	269,569.00	37.44	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet S-3
Part IV
Date/Time Prepared:
6/26/2020 1:35 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)	3,887,626	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	3,923,054	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	1,310,307	9.00
10.00	Dental, Hearing and Vision Plan	184,280	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	64,467	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	385,821	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	505,508	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	14,700	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	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	10,275,763	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet S-3
Part V
Date/Time Prepared:
6/26/2020 1:35 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	480,346	10,275,763	1.00
2.00	Hospital	480,346	7,419,001	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 OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	2,856,762	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0300	Period: From 12/01/2018 To 11/30/2019	Worksheet S-10 Date/Time Prepared: 6/26/2020 1:35 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)			0.774636 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	6,103,541		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			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	22,931,871		6.00
7.00	Medicaid cost (line 1 times line 6)	17,763,853		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)	11,660,312		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP	140,772		9.00
10.00	Stand-alone CHIP charges	128,686		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	99,685		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)	263,544		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	221,858		14.00
15.00	State or local indigent care program cost (line 1 times line 14)	171,859		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care	0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	11,660,312		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)	27,856,609	0	27,856,609 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	21,578,732	0	21,578,732 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)	21,578,732	0	21,578,732 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)	13,318,382		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	225,480		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	346,892		27.01
28.00	Non-Medicare bad debt expense (see instructions)	12,971,490		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	10,169,595		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	31,748,327		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	43,408,639		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0300

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

Worksheet A

Date/Time Prepared:
6/26/2020 1:35 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		925,781	925,781	0	925,781	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		507,376	507,376	0	507,376	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	79,806	5,615,166	5,694,972	0	5,694,972	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,192,912	24,764,070	26,956,982	0	26,956,982	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	2,284,356	3,817,795	6,102,151	0	6,102,151	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	121,590	121,590	0	121,590	8.00
9.00	00900	HOUSEKEEPING	1,149,267	342,691	1,491,958	0	1,491,958	9.00
10.00	01000	DIETARY	0	1,014,043	1,014,043	-882,587	131,456	10.00
11.00	01100	CAFETERIA	0	0	0	882,587	882,587	11.00
13.00	01300	NURSING ADMINISTRATION	1,024,265	1,237,549	2,261,814	0	2,261,814	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	250,012	910,724	1,160,736	0	1,160,736	14.00
15.00	01500	PHARMACY	2,790,858	259	2,791,117	0	2,791,117	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	147,723	0	147,723	0	147,723	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	13,184	13,184	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	891,862	891,862	22.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,298,272	0	4,298,272	-13,184	4,285,088	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,053,788	18,783	4,072,571	-170,543	3,902,028	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	523,310	0	523,310	0	523,310	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,719,695	1,506	1,721,201	0	1,721,201	54.00
60.00	06000	LABORATORY	1,605,242	40,155	1,645,397	0	1,645,397	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,244,095	424	1,244,519	0	1,244,519	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	804,619	210	804,829	0	804,829	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	1,885,404	1,885,404	0	1,885,404	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,997,082	1,997,082	0	1,997,082	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	67,369	195	67,564	0	67,564	90.00
91.00	09100	EMERGENCY	8,644,017	57,815	8,701,832	-721,319	7,980,513	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
	OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0	99.10
	SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,879,606	43,258,618	76,138,224	0	76,138,224	118.00
	NONREIMBURSABLE COST CENTERS							
200.00		TOTAL (SUM OF LINES 118 through 199)	32,879,606	43,258,618	76,138,224	0	76,138,224	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0300

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

Worksheet A

Date/Time Prepared:
6/26/2020 1:35 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,895,874	2,821,655	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	851,949	1,359,325	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,960,289	10,655,261	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,933,063	32,890,045	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	6,102,151	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	121,590	8.00
9.00	00900	HOUSEKEEPING	0	1,491,958	9.00
10.00	01000	DIETARY	0	131,456	10.00
11.00	01100	CAFETERIA	0	882,587	11.00
13.00	01300	NURSING ADMINISTRATION	-144,609	2,117,205	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,160,736	14.00
15.00	01500	PHARMACY	-192,949	2,598,168	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	147,723	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	13,184	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	-216,480	675,382	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,121,157	3,163,931	30.00
43.00	04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-1,569,763	2,332,265	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	-256,789	266,521	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-472,664	1,248,537	54.00
60.00	06000	LABORATORY	-211,127	1,434,270	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,244,519	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	-675,242	129,587	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	1,885,404	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-83,198	1,913,884	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	3,235,393	3,302,957	90.00
91.00	09100	EMERGENCY	-3,458,640	4,521,873	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,473,950	84,612,174	118.00
NONREIMBURSABLE COST CENTERS					
200.00		TOTAL (SUM OF LINES 118 through 199)	8,473,950	84,612,174	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 14-0300

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

Worksheet Non-CMS W

Date/Time Prepared:
6/26/2020 1:35 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
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
6.00	MAINTENANCE & REPAIRS	00600		6.00
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
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
21.00	I&R SERVICES-SALARY & FRINGES A	02100		21.00
22.00	I&R SERVICES-OTHER PRGM COSTS A	02200		22.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
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
60.01	BLOOD LABORATORY	06001		60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD	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 PAT	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				
88.00	RURAL HEALTH CLINIC	08800		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	08900		89.00
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT	09200		92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	CORF	09910		99.10
SPECIAL PURPOSE COST CENTERS				
109.00	PANCREAS ACQUISITION	10900		109.00
110.00	INTESTINAL ACQUISITION	11000		110.00
111.00	ISLET ACQUISITION	11100		111.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
NONREIMBURSABLE COST CENTERS				
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

RECLASSIFICATIONS

Provider CCN: 14-0300

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

Worksheet A-6

Date/Time Prepared:
6/26/2020 1:35 pm

Increases					
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
A - Cafeteria					
1.00 CAFETERIA	11.00	0	882,587		1.00
TOTALS		0	882,587		
B - Interns & Residents					
1.00 I&R SERVICES-SALARY & FRINGES A	21.00	13,184			1.00
		13,184	0		
C - Sengstacke Salaries					
1.00 CLINIC	90.00	3,161,621			1.00
		3,161,621	0		
D - Teaching Salaries					
1.00 I&R SERVICES-OTHER PRGM COSTS A	22.00	891,862			1.00
2.00					2.00
		891,862	0		
500.00 Grand Total: Increases		4,066,667	882,587		500.00

RECLASSIFICATIONS

Provider CCN: 14-0300

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

Worksheet A-6

Date/Time Prepared:
6/26/2020 1:35 pm

	Decreases						07/20/2020 1:00 pm
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1.00	A - Cafeteria						1.00
	DIETARY	10.00	0	882,587	0		
	TOTALS		0	882,587			
1.00	B - Interns & Residents						1.00
	ADULTS & PEDIATRICS	30.00	13,184				
			13,184	0			
1.00	C - Sengstacke Salaries						1.00
	CLINIC	90.00		3,161,621			
			0	3,161,621			
1.00	D - Teaching Salaries						1.00
	OPERATING ROOM	50.00	170,543				
	EMERGENCY	91.00	721,319				
2.00			891,862	0		2.00	
500.00	Grand Total: Decreases		905,046	4,044,208		500.00	

RECLASSIFICATIONS

Provider CCN: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
6/26/2020 1:35 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 - Cafeteria									
1.00	CAFETERIA	11.00	0	882,587	DIETARY	10.00	0	882,587	1.00
	TOTALS		0	882,587	TOTALS		0	882,587	
B - Interns & Residents									
1.00	I&R SERVICES-SALARY & FRINGES A	21.00	13,184		ADULTS & PEDIATRICS	30.00	13,184		1.00
			13,184	0			13,184	0	
C - Sengstacke Salaries									
1.00	CLINIC	90.00	3,161,621		CLINIC	90.00		3,161,621	1.00
			3,161,621	0			0	3,161,621	
D - Teaching Salaries									
1.00	I&R SERVICES-OTHER PRGM COSTS A	22.00	891,862		OPERATING ROOM	50.00	170,543		1.00
2.00					EMERGENCY	91.00	721,319		2.00
			891,862	0			891,862	0	
500.00	Grand Total: Increases		4,066,667	882,587	Grand Total: Decreases		905,046	4,044,208	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet A-7
Part I
Date/Time Prepared:
6/26/2020 1:35 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	0	0	0	0	0	1.00	
2.00	Land Improvements	0	0	0	0	0	2.00	
3.00	Buildings and Fixtures	52,370,437	0	0	0	155,929	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	108,487	0	0	0	0	5.00	
6.00	Movable Equipment	4,240,428	0	0	0	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	56,719,352	0	0	0	155,929	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	56,719,352	0	0	0	155,929	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0				1.00	
2.00	Land Improvements	0	0				2.00	
3.00	Buildings and Fixtures	52,214,508	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	108,487	0				5.00	
6.00	Movable Equipment	4,240,428	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	56,563,423	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	56,563,423	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet A-7
Part II
Date/Time Prepared:
6/26/2020 1:35 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	925,781	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	507,376	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,433,157	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	925,781				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	507,376				2.00
3.00	Total (sum of lines 1-2)	0	1,433,157				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet A-7
Part III
Date/Time Prepared:
6/26/2020 1:35 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	52,322,995	0	52,322,995	0.925032	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,240,428	0	4,240,428	0.074968	0	2.00
3.00	Total (sum of lines 1-2)	56,563,423	0	56,563,423	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	925,781	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	507,376	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,433,157	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	1,895,874	0	0	0	2,821,655	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	851,949	0	0	0	1,359,325	2.00
3.00	Total (sum of lines 1-2)	2,747,823	0	0	0	4,180,980	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0300

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

Worksheet A-8

Date/Time Prepared:
6/26/2020 1:35 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	-1,064	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	-125,065	ADMINISTRATIVE & GENERAL	5.00		9.00
11.00	Provider-based physician adjustment	A-8-2	-7,926,234				10.00
12.00	Sale of scrap, waste, etc. (chapter 23)						
13.00	Related organization transactions (chapter 10)	A-8-1	6,162,930				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	-192,949	PHARMACY	15.00		17.00
19.00	Sale of medical records and abstracts						
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	Misc. Income	B	-121,783	ADMINISTRATIVE & GENERAL	5.00		33.00

6/26/2020 1:35 pm Y:\15602 - Provident Hospital of Cook County\300 - Medicare Cost Report\20191130\HFS\15602-19.mcrx

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0300

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

Worksheet A-8

Date/Time Prepared:
6/26/2020 1:35 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.01	Sengstacke Cost from Stroger	A	759,108	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	Sengstacke Cost from Stroger	A	-145,331	DRUGS CHARGED TO PATIENTS	73.00	0	33.02
33.03	Sengstacke Cost from Stroger	A	3,235,393	CLINIC	90.00	0	33.03
33.04	Added Interest Capital	A	1,896,938	CAP REL COSTS-BLDG & FIXT	1.00	11	33.04
33.05	Added Interest Mvbl Equip Capital	A	851,949	CAP REL COSTS-MVBLE EQUIP	2.00	11	33.05
33.06	Added Interest Working Capital	A	704,256	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	Lobbying Dues	A	-7,205	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	Physicians' assistant	A	-250,975	OPERATING ROOM	50.00	0	33.08
33.09	Physicians' assistant	A	-253,644	EMERGENCY	91.00	0	33.09
33.10	Pension Cost	A	3,887,626	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		8,473,950				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: 14-0300

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

Worksheet A-8-1

Date/Time Prepared:
6/26/2020 1:35 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	CCHHS- Human Resources	313,555	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	CCHHS - CAPITAL	196,436	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	CCHHS - A&G	5,558,232	0	3.00
3.01	13.00	NURSING ADMINISTRATION	CCHHS - NURSING ADMIN	32,574	0	3.01
3.02	73.00	DRUGS CHARGED TO PATIENTS	CCHHS - DRUGS	62,133	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.			6,162,930	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	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	G	Cook County	100.00	Cook County	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	Government				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: 14-0300

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

Worksheet A-8-1

Date/Time Prepared:
6/26/2020 1:35 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	313,555	0		1.00
2.00	196,436	0		2.00
3.00	5,558,232	0		3.00
3.01	32,574	0		3.01
3.02	62,133	0		3.02
4.00	0	0		4.00
5.00	6,162,930			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: 14-0300

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

Worksheet A-8-2

Date/Time Prepared:
6/26/2020 1:35 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	271,808	271,808	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	177,183	177,183	0	0	0	2.00
3.00	22.00	I&R SERVICES-OTHER PRGM COSTS A	891,862	0	891,862	211,500	6,478	3.00
4.00	30.00	ADULTS & PEDIATRICS	1,389,904	849,386	372,045	179,000	3,042	4.00
5.00	50.00	OPERATING ROOM	1,476,651	1,281,151	162,224	246,400	1,307	5.00
6.00	53.00	ANESTHESIOLOGY	375,686	221,716	153,969	239,400	1,008	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	472,664	472,664	0	0	0	7.00
8.00	60.00	LABORATORY	211,127	211,127	0	0	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	675,242	675,242	0	0	0	9.00
10.00	91.00	EMERGENCY	3,689,294	3,023,108	565,110	246,400	3,999	10.00
200.00			9,631,421	7,183,385	2,145,210		15,834	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	5,084	1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0	3,314	2.00
3.00	22.00	I&R SERVICES-OTHER PRGM COSTS A	658,700	32,935	0	0	16,682	3.00
4.00	30.00	ADULTS & PEDIATRICS	261,788	13,089	0	0	25,998	4.00
5.00	50.00	OPERATING ROOM	154,829	7,741	0	0	27,621	5.00
6.00	53.00	ANESTHESIOLOGY	116,017	5,801	0	0	7,027	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	8,841	7.00
8.00	60.00	LABORATORY	0	0	0	0	3,949	8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	12,630	9.00
10.00	91.00	EMERGENCY	473,728	23,686	0	0	69,008	10.00
200.00			1,665,062	83,252	0	0	180,154	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	271,808		1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	177,183		2.00
3.00	22.00	I&R SERVICES-OTHER PRGM COSTS A	16,682	675,382	216,480	216,480		3.00
4.00	30.00	ADULTS & PEDIATRICS	6,959	268,747	103,298	1,121,157		4.00
5.00	50.00	OPERATING ROOM	3,034	157,863	4,361	1,318,788		5.00
6.00	53.00	ANESTHESIOLOGY	2,880	118,897	35,072	256,789		6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	472,664		7.00
8.00	60.00	LABORATORY	0	0	0	211,127		8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	675,242		9.00
10.00	91.00	EMERGENCY	10,570	484,298	80,812	3,204,996		10.00
200.00			40,125	1,705,187	440,023	7,926,234		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet B
Part I
Date/Time Prepared:
6/26/2020 1:35 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,821,655	2,821,655			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,359,325		1,359,325		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	10,655,261	28,794	0	10,684,055	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	32,890,045	551,617	282,268	651,510	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	9,488	31,856	0	6.00
7.00	00700	OPERATION OF PLANT	6,102,151	422,732	131,958	678,678	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	121,590	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,491,958	8,212	14,618	341,445	9.00
10.00	01000	DIETARY	131,456	91,244	0	0	10.00
11.00	01100	CAFETERIA	882,587	40,966	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,117,205	19,475	77,429	304,307	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,160,736	13,206	9,845	74,278	14.00
15.00	01500	PHARMACY	2,598,168	17,664	4,147	829,158	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	147,723	62,846	0	43,888	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	13,184	0	0	3,917	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	675,382	0	0	264,970	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,163,931	314,118	211,845	1,273,091	30.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,332,265	170,030	140,972	1,153,704	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	266,521	48,342	0	155,474	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,248,537	188,698	348,185	510,918	54.00
60.00	06000	LABORATORY	1,434,270	143,978	15,961	476,914	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	5,763	1,260	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	31,800	0	65.00
66.00	06600	PHYSICAL THERAPY	1,244,519	41,743	8,333	369,618	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	20,347	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	129,587	13,000	42,038	239,051	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,885,404	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	1,913,884	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	3,302,957	445,807	4,365	959,326	90.00
91.00	09100	EMERGENCY	4,521,873	163,585	2,445	2,353,808	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	84,612,174	2,821,655	1,359,325	10,684,055	118.00
NONREIMBURSABLE COST CENTERS							
200.00		Cross Foot Adjustments		0	0	0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	84,612,174	2,821,655	1,359,325	10,684,055	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet B
Part I
Date/Time Prepared:
6/26/2020 1:35 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
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	34,375,440					5.00
6.00	00600	MAINTENANCE & REPAIRS	28,290	69,634				6.00
7.00	00700	OPERATION OF PLANT	5,019,466	13,190	12,368,175			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	83,200	0	0	204,790		8.00
9.00	00900	HOUSEKEEPING	1,270,163	256	56,147	9,523	3,192,322	9.00
10.00	01000	DIETARY	152,387	2,847	623,828	0	0	10.00
11.00	01100	CAFETERIA	631,959	1,278	280,081	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,723,274	608	133,147	0	529,478	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	860,855	412	90,286	171	37,781	14.00
15.00	01500	PHARMACY	2,360,138	551	120,765	0	26,140	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	174,117	1,961	429,671	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	11,702	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	643,454	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,396,017	9,801	2,147,604	126,580	1,290,611	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,598,150	5,305	1,162,484	19,076	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	321,837	1,508	330,512	46	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,571,313	5,888	1,290,117	217	130,838	54.00
60.00	06000	LABORATORY	1,417,205	4,492	984,369	250	32,880	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	4,806	180	39,403	26	16,406	62.00
65.00	06500	RESPIRATORY THERAPY	21,760	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,138,769	1,302	285,395	119	13,819	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,923	635	139,113	7	5,514	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	289,908	406	88,882	40	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,290,124	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,309,611	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	3,224,587	13,910	3,047,952	26	0	90.00
91.00	09100	EMERGENCY	4,818,425	5,104	1,118,419	48,709	1,108,855	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,375,440	69,634	12,368,175	204,790	3,192,322	118.00
NONREIMBURSABLE COST CENTERS								
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)	34,375,440	69,634	12,368,175	204,790	3,192,322	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet B
Part I
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	1,001,762					10.00
11.00	01100	CAFETERIA	0	1,836,871				11.00
13.00	01300	NURSING ADMINISTRATION	0	70,716	4,975,639			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	2,247,570		14.00
15.00	01500	PHARMACY	0	0	0	1,038,427	6,995,158	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	84,768	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	828,105	925,440	1,505,252	187	1,080	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	156,610	1,267,406	54,650	316,164	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	121,481	36,995	10,074	58,282	54.00
60.00	06000	LABORATORY	0	116,790	0	65,929	381,411	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	15,615	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	76,804	0	12,712	73,540	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	15,803	0	2,468	14,279	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	1,049,601	6,072,176	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	13,511	78,162	90.00
91.00	09100	EMERGENCY	173,657	252,844	2,165,986	11	64	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,001,762	1,836,871	4,975,639	2,247,570	6,995,158	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,001,762	1,836,871	4,975,639	2,247,570	6,995,158	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0300

Period:
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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		Subtotal	
					SERVICES-SALAR Y & FRINGES A	SERVICES-OTHER PRGM COSTS A		
			16.00	17.00	21.00	22.00	24.00	
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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	944,974					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	28,803			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0		1,583,806		22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	49,913	0	18,613	1,023,459	16,285,647	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,673	0	3,068	168,692	9,553,249	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	1,694	93,165	1,219,099	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	115	0	1,316	72,361	5,595,335	54.00
60.00	06000	LABORATORY	345	0	0	0	5,074,794	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	83,459	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	53,560	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	3,266,673	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	179,539	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	835,462	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	10,297,305	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,223,495	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	535,673	0	0	0	11,626,276	90.00
91.00	09100	EMERGENCY	354,255	0	4,112	226,129	17,318,281	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	944,974	0	28,803	1,583,806	84,612,174	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments			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)	944,974	0	28,803	1,583,806	84,612,174	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0300

Period:
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Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
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
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A			22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,042,072	15,243,575	30.00
43.00	04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-171,760	9,381,489	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	-94,859	1,124,240	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-73,677	5,521,658	54.00
60.00	06000	LABORATORY	0	5,074,794	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	83,459	62.00
65.00	06500	RESPIRATORY THERAPY	0	53,560	65.00
66.00	06600	PHYSICAL THERAPY	0	3,266,673	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	179,539	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	835,462	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	10,297,305	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,223,495	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	11,626,276	90.00
91.00	09100	EMERGENCY	-230,241	17,088,040	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0		92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,612,609	82,999,565	118.00
NONREIMBURSABLE COST CENTERS					
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	-1,612,609	82,999,565	202.00

COST ALLOCATION STATISTICS

Provider CCN: 14-0300

Period:

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

Worksheet Non-CMS W

Date/Time Prepared:
6/26/2020 1:35 pm

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
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
6.00	MAINTENANCE & REPAIRS	1	SQUARE FEET	6.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	3	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	4	HOURS OF SERVICE	9.00
10.00	DIETARY	5	MEALS SERVED	10.00
11.00	CAFETERIA	6	MEALS SERVED	11.00
13.00	NURSING ADMINISTRATION	7	DIRECT NRS ING	13.00
14.00	CENTRAL SERVICES & SUPPLY	8	COSTED REQUIS.	14.00
15.00	PHARMACY	8	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	9	TIME SPENT	16.00
17.00	SOCIAL SERVICE	10	TIME SPENT	17.00
21.00	I&R SERVICES-SALARY & FRINGES A	11	ASSIGNED TIME	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS A	12	ASSIGNED TIME	22.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			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	28,794	28,794	28,794	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	196,436	551,617	1,030,321	1,757	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	9,488	41,344	0	6.00
7.00	00700	OPERATION OF PLANT	0	422,732	131,958	1,830	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	8,212	14,618	921	9.00
10.00	01000	DIETARY	0	91,244	0	0	10.00
11.00	01100	CAFETERIA	0	40,966	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	19,475	77,429	820	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	13,206	9,845	200	14.00
15.00	01500	PHARMACY	0	17,664	4,147	2,235	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	62,846	0	118	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	11	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	714	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	314,118	211,845	525,963	30.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	170,030	140,972	311,002	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	48,342	0	419	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	188,698	348,185	1,377	54.00
60.00	06000	LABORATORY	0	143,978	15,961	1,286	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	5,763	1,260	7,023	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	31,800	31,800	65.00
66.00	06600	PHYSICAL THERAPY	0	41,743	8,333	50,076	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	20,347	0	20,347	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	13,000	42,038	55,038	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	445,807	4,365	450,172	90.00
91.00	09100	EMERGENCY	0	163,585	2,445	166,030	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT			0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	196,436	2,821,655	1,359,325	4,377,416	118.00
NONREIMBURSABLE COST CENTERS							
200.00		Cross Foot Adjustments			0		200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	196,436	2,821,655	1,359,325	4,377,416	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet B
Part II
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,032,078					5.00
6.00	00600	MAINTENANCE & REPAIRS	849	42,193				6.00
7.00	00700	OPERATION OF PLANT	150,715	7,992	715,227			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,498	0	0	2,498		8.00
9.00	00900	HOUSEKEEPING	38,134	155	3,247	116	65,403	9.00
10.00	01000	DIETARY	4,575	1,725	36,075	0	0	10.00
11.00	01100	CAFETERIA	18,973	774	16,197	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	51,738	368	7,700	0	10,848	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	25,846	250	5,221	2	774	14.00
15.00	01500	PHARMACY	70,859	334	6,984	0	536	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,228	1,188	24,847	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	351	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	19,319	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	101,960	5,939	124,192	1,545	26,440	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	78,005	3,215	67,224	233	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	9,663	914	19,113	1	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	47,176	3,567	74,605	3	2,681	54.00
60.00	06000	LABORATORY	42,549	2,722	56,924	3	674	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	144	109	2,279	0	336	62.00
65.00	06500	RESPIRATORY THERAPY	653	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	34,190	789	16,504	1	283	66.00
67.00	06700	OCCUPATIONAL THERAPY	418	385	8,045	0	113	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,704	246	5,140	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	38,734	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,319	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	96,813	8,428	176,254	0	0	90.00
91.00	09100	EMERGENCY	144,665	3,093	64,676	594	22,718	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,032,078	42,193	715,227	2,498	65,403	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,032,078	42,193	715,227	2,498	65,403	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
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
6.00	00600	MAINTENANCE & REPAIRS					6.00
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	133,619				10.00
11.00	01100	CAFETERIA	0	76,910			11.00
13.00	01300	NURSING ADMINISTRATION	0	2,961	171,339		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	55,344	14.00
15.00	01500	PHARMACY	0	0	0	25,571	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,549	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	110,456	38,748	51,834	5	30.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	6,557	43,644	1,346	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	5,086	1,274	248	54.00
60.00	06000	LABORATORY	0	4,890	0	1,623	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	654	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,216	0	313	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	662	0	61	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	25,844	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	333	90.00
91.00	09100	EMERGENCY	23,163	10,587	74,587	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT					92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	133,619	76,910	171,339	55,344	118.00
NONREIMBURSABLE COST CENTERS							
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)	133,619	76,910	171,339	55,344	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		Subtotal	
					SERVICES-SALAR Y & FRINGES A	SERVICES-OTHER PRGM COSTS A		
			16.00	17.00	21.00	22.00	24.00	
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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	97,776					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	362			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0		20,033		22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,164	0			995,698	30.00
43.00	04300	NURSERY	0	0			0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	484	0			520,620	50.00
51.00	05100	RECOVERY ROOM	0	0			0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0			0	52.00
53.00	05300	ANESTHESIOLOGY	0	0			78,452	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12	0			673,981	54.00
60.00	06000	LABORATORY	36	0			277,643	60.00
60.01	06001	BLOOD LABORATORY	0	0			0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0			10,545	62.00
65.00	06500	RESPIRATORY THERAPY	0	0			32,453	65.00
66.00	06600	PHYSICAL THERAPY	0	0			107,718	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0			29,308	67.00
68.00	06800	SPEECH PATHOLOGY	0	0			0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0			70,757	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0			175,976	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0			0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0			39,319	73.00
74.00	07400	RENAL DIALYSIS	0	0			0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0			0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	89.00
90.00	09000	CLINIC	55,425	0			791,445	90.00
91.00	09100	EMERGENCY	36,655	0			553,106	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0			0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0			0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0			0	110.00
111.00	11100	ISLET ACQUISITION	0	0			0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	97,776	0	0	0	4,357,021	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments			362	20,033	20,395	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	97,776	0	362	20,033	4,377,416	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet B
Part II
Date/Time Prepared:
6/26/2020 1:35 pm

Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
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
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A			22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	995,698	30.00
43.00	04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	520,620	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	78,452	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	673,981	54.00
60.00	06000	LABORATORY	0	277,643	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	10,545	62.00
65.00	06500	RESPIRATORY THERAPY	0	32,453	65.00
66.00	06600	PHYSICAL THERAPY	0	107,718	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	29,308	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	70,757	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	175,976	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	39,319	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	791,445	90.00
91.00	09100	EMERGENCY	0	553,106	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0		92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,357,021	118.00
NONREIMBURSABLE COST CENTERS					
200.00		Cross Foot Adjustments	0	20,395	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	4,377,416	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0300

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

Worksheet B-1

Date/Time Prepared:
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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	384,823				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,114,784			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,927	0	35,961,421		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	75,231	231,488	2,192,912	-34,375,440	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,294	26,125	0	0	6.00
7.00	00700	OPERATION OF PLANT	57,653	108,219	2,284,356	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,120	11,988	1,149,267	0	9.00
10.00	01000	DIETARY	12,444	0	0	0	10.00
11.00	01100	CAFETERIA	5,587	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,656	63,500	1,024,265	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,801	8,074	250,012	0	14.00
15.00	01500	PHARMACY	2,409	3,401	2,790,858	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,571	0	147,723	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	13,184	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	891,862	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	42,840	173,734	4,285,088	0	30.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	23,189	115,611	3,883,245	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	6,593	0	523,310	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,735	285,548	1,719,695	0	54.00
60.00	06000	LABORATORY	19,636	13,090	1,605,242	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	786	1,033	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	26,079	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,693	6,834	1,244,095	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,775	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,773	34,475	804,619	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	60,800	3,580	3,228,990	0	90.00
91.00	09100	EMERGENCY	22,310	2,005	7,922,698	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT					92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	384,823	1,114,784	35,961,421	-34,375,440	118.00
NONREIMBURSABLE COST CENTERS							
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,821,655	1,359,325	10,684,055	34,375,440	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.332345	1.219362	0.297098	0.684269	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			28,794	1,032,078	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000801	0.020544	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: 14-0300

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			6.00	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						5.00
6.00	00600	MAINTENANCE & REPAIRS	304,371					6.00
7.00	00700	OPERATION OF PLANT	57,653	246,718				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	486,312			8.00
9.00	00900	HOUSEKEEPING	1,120	1,120	22,614	46,895		9.00
10.00	01000	DIETARY	12,444	12,444	0	0	21,142	10.00
11.00	01100	CAFETERIA	5,587	5,587	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,656	2,656	0	7,778	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,801	1,801	407	555	0	14.00
15.00	01500	PHARMACY	2,409	2,409	0	384	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,571	8,571	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	42,840	42,840	300,588	18,959	17,477	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	23,189	23,189	45,300	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	6,593	6,593	110	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,735	25,735	516	1,922	0	54.00
60.00	06000	LABORATORY	19,636	19,636	594	483	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	786	786	61	241	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,693	5,693	282	203	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,775	2,775	16	81	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,773	1,773	94	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	60,800	60,800	62	0	0	90.00
91.00	09100	EMERGENCY	22,310	22,310	115,668	16,289	3,665	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	304,371	246,718	486,312	46,895	21,142	118.00
NONREIMBURSABLE COST CENTERS								
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)	69,634	12,368,175	204,790	3,192,322	1,001,762	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.228780	50.130817	0.421108	68.073825	47.382556	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	42,193	715,227	2,498	65,403	133,619	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.138624	2.898966	0.005137	1.394669	6.320074	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: 14-0300

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

Worksheet B-1

Date/Time Prepared:
6/26/2020 1:35 pm

Cost Center Description			CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	88,108					11.00
13.00	01300	NURSING ADMINISTRATION	3,392	146,061				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	4,239,763			14.00
15.00	01500	PHARMACY	0	0	1,958,864	2,280,899		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,066	0	0	0	24,669	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	44,390	44,187	352	352	1,303	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,512	37,205	103,091	103,091	122	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,827	1,086	19,004	19,004	3	54.00
60.00	06000	LABORATORY	5,602	0	124,366	124,366	9	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	749	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,684	0	23,979	23,979	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	758	0	4,656	4,656	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	1,979,944	1,979,944	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	25,486	25,486	13,984	90.00
91.00	09100	EMERGENCY	12,128	63,583	21	21	9,248	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	88,108	146,061	4,239,763	2,280,899	24,669	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,836,871	4,975,639	2,247,570	6,995,158	944,974	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	20.847948	34.065486	0.530117	3.066843	38.306133	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	76,910	171,339	55,344	128,330	97,776	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.872906	1.173065	0.013054	0.056263	3.963517	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: 14-0300

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

Worksheet B-1

Date/Time Prepared:
6/26/2020 1:35 pm

Cost Center Description		INTERNS & RESIDENTS			
		SOCIAL SERVICE (TIME SPENT)	SERVICES-SALAR Y & FRINGES A	SERVICES-OTHER PRGM COSTS A	
			(ASSIGNED TIME)	(ASSIGNED TIME)	
		17.00	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
6.00	00600	MAINTENANCE & REPAIRS			6.00
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
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE	0		17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	3,502		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	3,502	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	2,263	30.00
43.00	04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	373	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	206	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	160	54.00
60.00	06000	LABORATORY	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	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 PAT	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					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	500	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,502	118.00
NONREIMBURSABLE COST CENTERS					
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)	0	28,803	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	8.224729	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	362	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.103370	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

Worksheet C
Part I
Date/Time Prepared:
6/26/2020 1:35 pm

6/26/2020 1:35 pm Y:\15602 - Provident Hospital of Cook County\300 - Medicare Cost Report\20191130\HES\15602-19.mcrx

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet C
Part I
Date/Time Prepared:
6/26/2020 1:35 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	6,842,118		6,842,118			30.00
43.00	04300	NURSERY	0		0			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	252,338	12,089,470	12,341,808	0.760139	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	27,240	2,087,048	2,114,288	0.531735	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	752,212	11,797,063	12,549,275	0.439998	0.000000	54.00
60.00	06000	LABORATORY	821,811	10,466,938	11,288,749	0.449544	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	606	37,052	37,658	2.216236	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	602,854	418,688	1,021,542	0.052431	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	47,535	1,370,021	1,417,556	2.304440	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,448	234,577	238,025	0.754286	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	54,866	814,516	869,382	0.960984	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	19,223	964,546	983,769	10.467198	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,386,763	4,005,161	5,391,924	0.597838	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	0	31,667,662	31,667,662	0.367134	0.000000	90.00
91.00	09100	EMERGENCY	376,908	16,765,508	17,142,416	0.996828	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	401,092	2,839,253	3,240,345	0.933864	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0			99.10
	SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
200.00		Subtotal (see instructions)	11,589,014	95,557,503	107,146,517			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	11,589,014	95,557,503	107,146,517			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.760492			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	0.548323			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.439998			54.00
60.00	06000	LABORATORY	0.449544			60.00
60.01	06001	BLOOD LABORATORY	0.000000			60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	2.216236			62.00
65.00	06500	RESPIRATORY THERAPY	0.052431			65.00
66.00	06600	PHYSICAL THERAPY	2.304440			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.754286			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.960984			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	10.467198			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.597838			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000	CLINIC	0.367134			90.00
91.00	09100	EMERGENCY	1.001542			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.933864			92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION				109.00
110.00	11000	INTESTINAL ACQUISITION				110.00
111.00	11100	ISLET ACQUISITION				111.00
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: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet C
Part I
Date/Time Prepared:
6/26/2020 1:35 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	15,243,575		15,243,575	103,298
43.00	04300	NURSERY	0		0	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,381,489		9,381,489	4,361
51.00	05100	RECOVERY ROOM	0		0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0
53.00	05300	ANESTHESIOLOGY	1,124,240		1,124,240	35,072
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,521,658		5,521,658	0
60.00	06000	LABORATORY	5,074,794		5,074,794	0
60.01	06001	BLOOD LABORATORY	0		0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	83,459		83,459	0
65.00	06500	RESPIRATORY THERAPY	53,560	0	53,560	0
66.00	06600	PHYSICAL THERAPY	3,266,673	0	3,266,673	0
67.00	06700	OCCUPATIONAL THERAPY	179,539	0	179,539	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	835,462		835,462	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	10,297,305		10,297,305	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	3,223,495		3,223,495	0
74.00	07400	RENAL DIALYSIS	0		0	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0
90.00	09000	CLINIC	11,626,276		11,626,276	0
91.00	09100	EMERGENCY	17,088,040		17,088,040	80,812
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	3,026,041		3,026,041	0
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0	0
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0		0	0
110.00	11000	INTESTINAL ACQUISITION	0		0	0
111.00	11100	ISLET ACQUISITION	0		0	0
200.00		Subtotal (see instructions)	86,025,606	0	86,025,606	223,543
201.00		Less Observation Beds	3,026,041		3,026,041	0
202.00		Total (see instructions)	82,999,565	0	82,999,565	223,543

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet C
Part I
Date/Time Prepared:
6/26/2020 1:35 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	6,842,118		6,842,118		
43.00	04300	NURSERY	0		0		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	252,338	12,089,470	12,341,808	0.760139	0.000000
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000
53.00	05300	ANESTHESIOLOGY	27,240	2,087,048	2,114,288	0.531735	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	752,212	11,797,063	12,549,275	0.439998	0.000000
60.00	06000	LABORATORY	821,811	10,466,938	11,288,749	0.449544	0.000000
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	606	37,052	37,658	2.216236	0.000000
65.00	06500	RESPIRATORY THERAPY	602,854	418,688	1,021,542	0.052431	0.000000
66.00	06600	PHYSICAL THERAPY	47,535	1,370,021	1,417,556	2.304440	0.000000
67.00	06700	OCCUPATIONAL THERAPY	3,448	234,577	238,025	0.754286	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000
69.00	06900	ELECTROCARDIOLOGY	54,866	814,516	869,382	0.960984	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	19,223	964,546	983,769	10.467198	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	1,386,763	4,005,161	5,391,924	0.597838	0.000000
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000
90.00	09000	CLINIC	0	31,667,662	31,667,662	0.367134	0.000000
91.00	09100	EMERGENCY	376,908	16,765,508	17,142,416	0.996828	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	401,092	2,839,253	3,240,345	0.933864	0.000000
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0		
110.00	11000	INTESTINAL ACQUISITION	0	0	0		
111.00	11100	ISLET ACQUISITION	0	0	0		
200.00		Subtotal (see instructions)	11,589,014	95,557,503	107,146,517		
201.00		Less Observation Beds					
202.00		Total (see instructions)	11,589,014	95,557,503	107,146,517		

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet C
Part I
Date/Time Prepared:
6/26/2020 1:35 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
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
60.01	06001	BLOOD LABORATORY	0.000000			60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	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 PAT	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						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION				109.00
110.00	11000	INTESTINAL ACQUISITION				110.00
111.00	11100	ISLET ACQUISITION				111.00
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: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet D
Part I
Date/Time Prepared:
6/26/2020 1:35 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)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		995,698	0	995,698	4,179	238.26	30.00
43.00	NURSERY		0		0	0	0.00	43.00
200.00	Total (lines 30 through 199)		995,698		995,698	4,179		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		295	70,287				
43.00	NURSERY		0	0				
200.00	Total (lines 30 through 199)		295	70,287				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet D
Part II
Date/Time Prepared:
6/26/2020 1:35 pm

				Title XVIII		Hospital		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	520,620	12,341,808	0.042183	38,874	1,640	50.00	
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	78,452	2,114,288	0.037106	4,528	168	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	673,981	12,549,275	0.053707	78,876	4,236	54.00	
60.00	06000	LABORATORY	277,643	11,288,749	0.024595	102,380	2,518	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	10,545	37,658	0.280020	0	0	62.00	
65.00	06500	RESPIRATORY THERAPY	32,453	1,021,542	0.031769	57,608	1,830	65.00	
66.00	06600	PHYSICAL THERAPY	107,718	1,417,556	0.075989	7,356	559	66.00	
67.00	06700	OCCUPATIONAL THERAPY	29,308	238,025	0.123130	745	92	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	70,757	869,382	0.081388	54,866	4,465	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	175,976	983,769	0.178879	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	39,319	5,391,924	0.007292	111,615	814	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00	
90.00	09000	CLINIC	791,445	31,667,662	0.024992	0	0	90.00	
91.00	09100	EMERGENCY	553,106	17,142,416	0.032265	58,599	1,891	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	196,330	3,240,345	0.060589	68,250	4,135	92.00	
200.00		Total (lines 50 through 199)	3,557,653	100,304,399		583,697	22,348	200.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0300		Period: From 12/01/2018 To 11/30/2019		Worksheet D Part III Date/Time Prepared: 6/26/2020 1:35 pm	
					Title XVIII		Hospital		PPS	
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00		
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	4,179	0.00	295	30.00		
43.00	04300	NURSERY		0	0	0.00	0	43.00		
200.00		Total (lines 30 through 199)		0	4,179		295	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	
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: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet D
Part IV
Date/Time Prepared:
6/26/2020 1:35 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
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	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 PAT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet D
Part IV
Date/Time Prepared:
6/26/2020 1:35 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	12,341,808	0.000000	50.00	
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	2,114,288	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,549,275	0.000000	54.00	
60.00	06000	LABORATORY	0	0	0	11,288,749	0.000000	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	37,658	0.000000	62.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,021,542	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	1,417,556	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	238,025	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	869,382	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	983,769	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,391,924	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00	
90.00	09000	CLINIC	0	0	0	31,667,662	0.000000	90.00	
91.00	09100	EMERGENCY	0	0	0	17,142,416	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	3,240,345	0.000000	92.00	
200.00		Total (lines 50 through 199)	0	0	0	100,304,399		200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0300

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

Worksheet D
Part IV
Date/Time Prepared:
6/26/2020 1:35 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	38,874	0	1,489,760	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	4,528	0	128,512	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	78,876	0	967,137	0	54.00
60.00	06000	LABORATORY	0.000000	102,380	0	658,312	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.000000	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	57,608	0	45,473	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	7,356	0	1,249	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	745	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	54,866	0	297,829	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	0	0	3,750	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	111,615	0	302,752	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	1,784,065	0	90.00
91.00	09100	EMERGENCY	0.000000	58,599	0	1,018,566	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.000000	68,250	0	342,484	0	92.00
200.00		Total (lines 50 through 199)		583,697	0	7,039,889	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet D
Part IV
Date/Time Prepared:
6/26/2020 1:35 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
60.01	06001	BLOOD LABORATORY	0	0					60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	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 PAT	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								
88.00	08800	RURAL HEALTH CLINIC	0	0					88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0					89.00
90.00	09000	CLINIC	0	0					90.00
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	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: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet D
Part V
Date/Time Prepared:
6/26/2020 1:35 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	0.760139	1,489,760	0	0	1,132,425	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.531735	128,512	0	0	68,334	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.439998	967,137	0	0	425,538	54.00
60.00	06000	LABORATORY	0.449544	658,312	0	0	295,940	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	2.216236	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.052431	45,473	0	0	2,384	65.00
66.00	06600	PHYSICAL THERAPY	2.304440	1,249	0	0	2,878	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.754286	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.960984	297,829	0	0	286,209	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	10.467198	3,750	0	0	39,252	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.597838	302,752	3,228	120,595	180,997	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.367134	1,784,065	0	70	654,991	90.00
91.00	09100	EMERGENCY	0.996828	1,018,566	0	0	1,015,335	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.933864	342,484	0	0	319,833	92.00
200.00		Subtotal (see instructions)		7,039,889	3,228	120,665	4,424,116	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		7,039,889	3,228	120,665	4,424,116	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet D
Part V
Date/Time Prepared:
6/26/2020 1:35 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
60.01	06001	BLOOD LABORATORY	0	0		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	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 PAT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,930	72,096		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	26		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0		92.00
200.00		Subtotal (see instructions)	1,930	72,122		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	1,930	72,122		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0300	Period: From 12/01/2018 To 11/30/2019	Worksheet D-1 Date/Time Prepared: 6/26/2020 1:35 pm	
		Title XVIII	Hospital	PPS	
Cost Center Description				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			4,179	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			4,179	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			3,355	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)			295	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)			15,346,873	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)			15,346,873	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)			15,346,873	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)			3,672.38	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,083,352	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			1,083,352	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0300

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

Worksheet D-1

Date/Time Prepared:
6/26/2020 1:35 pm

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospital Program Days	Program Cost (col. 3 x col. 4)	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						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					375,186	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,458,538	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)					70,287	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					22,348	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					92,635	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,365,903	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)					824	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					3,672.38	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,026,041	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0300

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

Worksheet D-1

Date/Time Prepared:
6/26/2020 1:35 pm

			Title XVIII		Hospital	PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
		COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
90.00	Capital-related cost	995,698	15,346,873	0.064880	3,026,041	196,330	90.00
91.00	Nursing School cost	0	15,346,873	0.000000	3,026,041	0	91.00
92.00	Allied health cost	0	15,346,873	0.000000	3,026,041	0	92.00
93.00	All other Medical Education	0	15,346,873	0.000000	3,026,041	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0300	Period: From 12/01/2018 To 11/30/2019	Worksheet D-3 Date/Time Prepared: 6/26/2020 1:35 pm
			Title XVIII	Hospital	PPS
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		530,850	30.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.760492	38,874	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.548323	4,528	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.439998	78,876	54.00
60.00	06000	LABORATORY	0.449544	102,380	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	2.216236	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.052431	57,608	65.00
66.00	06600	PHYSICAL THERAPY	2.304440	7,356	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.754286	745	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.960984	54,866	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	10.467198	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.597838	111,615	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.367134	0	90.00
91.00	09100	EMERGENCY	1.001542	58,599	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.933864	68,250	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		583,697	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)		583,697	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet E
Part A
Date/Time Prepared:
6/26/2020 1:35 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)			351,479	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			90,185	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)			0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			0	2.04
3.00	Managed Care Simulated Payments			203,884	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			22.74	4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)			0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			11.59	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)			0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)			11.59	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			4.08	10.00
11.00	FTE count for residents in dental and podiatric programs.			0.00	11.00
12.00	Current year allowable FTE (see instructions)			4.08	12.00
13.00	Total allowable FTE count for the prior year.			2.40	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.			2.91	14.00
15.00	Sum of lines 12 through 14 divided by 3.			3.13	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			3.13	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.137643	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.098684	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.098684	21.00
22.00	IME payment adjustment (see instructions)			23,165	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			10,694	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)			-7.51	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)			23,165	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			10,694	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			9.95	30.00
31.00	Percentage of Medicaid patient days (see instructions)			27.93	31.00
32.00	Sum of lines 30 and 31			37.88	32.00
33.00	Allowable disproportionate share percentage (see instructions)			12.00	33.00
34.00	Disproportionate share adjustment (see instructions)			13,250	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0300	Period: From 12/01/2018 To 11/30/2019	Worksheet E Part A Date/Time Prepared: 6/26/2020 1:35 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)	4,426,596	5,991,585	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	3,686,810	998,599	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	4,685,409		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)	5,163,488		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)		5,174,182	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		39,398	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).		10,191	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		5,223,771	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		5,223,771	61.00
62.00	Deductibles billed to program beneficiaries		76,336	62.00
63.00	Coinsurance billed to program beneficiaries		0	63.00
64.00	Allowable bad debts (see instructions)		31,763	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		20,646	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		2,728	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		5,168,081	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)		0	70.93
70.94	HRR adjustment amount (see instructions)		0	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet E
Part A
Date/Time Prepared:
6/26/2020 1:35 pm

		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96	
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97	
70.98	Low Volume Payment-3		0	70.98	
70.99	HAC adjustment amount (see instructions)		0	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		5,168,081	71.00	
71.01	Sequestration adjustment (see instructions)		103,362	71.01	
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	
72.00	Interim payments		4,000,974	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)		1,063,745	74.00	
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	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)		207,800	90.00	
91.00	Capital outlier from Wkst. L, Pt. I, line 2		21,009	91.00	
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00	
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00	
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00	
95.00	Time value of money for operating expenses (see instructions)		0	95.00	
96.00	Time value of money for capital related expenses (see instructions)		0	96.00	
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	100.00	
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)	1.0000000000	1.0000000000	101.00	
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00	
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)	0.9983	0.9983	103.00	
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00	
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00	
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00	
202.00	Medicare discharges (see instructions)			202.00	
203.00	Case-mix adjustment factor (see instructions)			203.00	
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount			204.00	
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00	
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00	
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00	
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00	
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00	
210.00	Reserved for future use			210.00	
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00	
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00	
213.00	Low-volume adjustment (see instructions)			213.00	
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00	

CALCULATION OF DSH PAYMENT PERCENTAGE

Provider CCN: 14-0300

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

Worksheet DSH

Date/Time Prepared:
6/26/2020 1:35 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)	9.95	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	27.93	0.00			27.93	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	37.88	0.00			27.93	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)	22.74	0.00			22.74	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	12.00	0.00			12.26	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)?	No				No	9.00
10.00	S-2, Line 45	No				No	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)	0.00	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)	334	0			334	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)	603	0			603	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)	937	0			937	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	3,355	0			3,355	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	0	0			0	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)	3,355	0			3,355	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	27.93	0.00			27.93	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE

Provider CCN: 14-0300

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

Worksheet DSH

Date/Time Prepared:
6/26/2020 1:35 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	20.47		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		20.47		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.		20.47		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 ammendment? (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: 14-0300

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

Worksheet DSH

Date/Time Prepared:
6/26/2020 1:35 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	12.26		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	12.26		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.	12.26		31.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
6/26/2020 1:35 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	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	351,479	0	351,479		351,479	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	90,185	0		90,185	90,185	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	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	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	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	203,884	0	163,069	40,816	203,885	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.098684	0.098684	0.098684	0.098684		5.00
6.00	IME payment adjustment (see instructions)	22.00	23,165	0	18,435	4,730	23,165	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	10,694	0	8,553	2,141	10,694	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	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	23,165	0	18,435	4,730	23,165	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	10,694	0	8,553	2,141	10,694	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	13,250	0	10,544	2,706	13,250	11.00
11.01	Uncompensated care payments	36.00	4,685,409	0	2,560,482	1,045,044	3,605,526	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	0	12.00
13.00	Subtotal (see instructions)	47.00	5,163,488	0	4,020,823	1,142,665	5,163,488	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	5,174,182	0	4,029,376	1,144,806	5,174,182	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	39,398	0	31,480	7,918	39,398	16.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
6/26/2020 1:35 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	4,060,856	1,152,724	5,213,580
		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	35,787	0	28,595	7,192	35,787
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	0	0	0	0	0
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	0.1009	0.1009	0.1009	0.1009	
23.00	Indirect medical education adjustment (see instructions)	6.00	3,611	0	2,885	726	3,611
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0
26.00	Total prospective capital payments (see instructions)	12.00	39,398	0	31,480	7,918	39,398
		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				0.250000	0.250000	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			1,015,214		1,015,214
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				288,181	288,181
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
6/26/2020 1:35 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	351,479	351,479		351,479	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	90,185		90,185	90,185	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	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	203,884	163,069	40,816	203,885	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.098684	0.098684	0.098684		5.00
6.00	IME payment adjustment (see instructions)	22.00	23,165	18,435	4,730	23,165	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	10,694	8,553	2,141	10,694	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	23,165	18,435	4,730	23,165	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	10,694	8,553	2,141	10,694	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	13,250	10,544	2,706	13,250	11.00
11.01	Uncompensated care payments	36.00	4,685,409	2,560,482	1,045,044	3,605,526	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	5,163,488	4,020,823	1,142,665	5,163,488	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	5,174,182	4,029,376	1,144,806	5,174,182	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	39,398	31,480	7,918	39,398	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			4,060,856	1,152,724	5,213,580	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
6/26/2020 1:35 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	35,787	28,595	7,192	35,787	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	0	0	0	0	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	0.1009	0.1009	0.1009		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	3,611	2,885	726	3,611	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	39,398	31,480	7,918	39,398	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	0	0	0	0	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	0	0	0	0	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.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0300	Period: From 12/01/2018 To 11/30/2019	Worksheet E Part B Date/Time Prepared: 6/26/2020 1:35 pm
		Title XVIII	Hospital	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		74,052	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		4,424,116	2.00
3.00	OPPS payments		2,685,644	3.00
4.00	Outlier payment (see instructions)		104,240	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		74,052	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		123,893	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)		123,893	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)		123,893	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		49,841	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)		74,052	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)		2,789,884	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)		659,726	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)		2,204,210	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		31,431	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)		2,235,641	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		2,235,641	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)		315,129	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		204,834	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		28,369	36.00
37.00	Subtotal (see instructions)		2,440,475	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)		2,440,475	40.00
40.01	Sequestration adjustment (see instructions)		48,810	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		2,177,923	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		213,742	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)		118,819	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: 14-0300	Period: From 12/01/2018 To 11/30/2019	Worksheet E Part B Date/Time Prepared: 6/26/2020 1:35 pm
		Title XVIII	Hospital	PPS
				Overrides
				1.00
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)			0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet E-1
Part I
Date/Time Prepared:
6/26/2020 1:35 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		4,000,974		2,177,923	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,000,974		2,177,923	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		1,063,745		213,742	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		5,064,719		2,391,665	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.		06101		8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet E-1
Part II
Date/Time Prepared:
6/26/2020 1:35 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

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0300	Period: From 12/01/2018 To 11/30/2019	Worksheet E-4 Date/Time Prepared: 6/26/2020 1:35 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.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			11.59	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	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))			0.00	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)			11.59	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			4.08	6.00
7.00	Enter the lesser of line 5 or line 6			4.08	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.	0.00	2.91	2.91	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.	0.00	2.91	2.91	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		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	0.00	2.91		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	2.34		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.36	2.52		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.12	2.59		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	0.12	2.59		17.00
18.00	Per resident amount	127,527.54	113,790.56		18.00
19.00	Approved amount for resident costs	15,303	294,718	310,021	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)			0.00	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)			310,021	25.00
		Inpatient Part	Managed care		
		A			
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	295	181		26.00
27.00	Total Inpatient Days (see instructions)	3,355	3,355		27.00
28.00	Ratio of inpatient days to total inpatient days	0.087928	0.053949		28.00
29.00	Program direct GME amount	27,260	16,725		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		2,363		30.00
31.00	Net Program direct GME amount			41,622	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0300	Period: From 12/01/2018 To 11/30/2019	Worksheet E-4 Date/Time Prepared: 6/26/2020 1:35 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)			0	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)			0	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)			1,458,538	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)			1,458,538	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			4,498,168	42.00
43.00	Primary payer payments (see instructions)			0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			4,498,168	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			5,956,706	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.244856	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.755144	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			41,622	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			10,191	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			31,431	50.00

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

Provider CCN: 14-0300

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

Worksheet G

Date/Time Prepared:
6/26/2020 1:35 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	367,745,109	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	120,533,285	0	0	0	4.00
5.00 Other receivable	-208,338,546	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-105,554	0	0	0	6.00
7.00 Inventory	503,673	0	0	0	7.00
8.00 Prepaid expenses	0	0	0	0	8.00
9.00 Other current assets	0	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)	280,337,967	0	0	0	11.00
FIXED ASSETS					
12.00 Land	0	0	0	0	12.00
13.00 Land improvements	0	0	0	0	13.00
14.00 Accumulated depreciation	0	0	0	0	14.00
15.00 Buildings	52,214,508	0	0	0	15.00
16.00 Accumulated depreciation	-36,156,565	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	108,487	0	0	0	19.00
20.00 Accumulated depreciation	-90,567	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	4,240,428	0	0	0	23.00
24.00 Accumulated depreciation	-3,125,644	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)	17,190,647	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)	297,528,614	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	2,077,373	0	0	0	37.00
38.00 Salaries, wages, and fees payable	2,258,368	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	1,116,336	0	0	0	43.00
44.00 Other current liabilities	0	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	5,452,077	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)	5,452,077	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	292,076,537	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)	292,076,537	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	297,528,614	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0300

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

Worksheet G-1

Date/Time Prepared:
6/26/2020 1:35 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		291,160,597		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		163,393				2.00
3.00	Total (sum of line 1 and line 2)		291,323,990		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00	OTHER ADJUSTMENTS	752,547		0		0	9.00
10.00	Total additions (sum of line 4-9)		752,547		0		10.00
11.00	Subtotal (line 3 plus line 10)		292,076,537		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		292,076,537		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00	OTHER ADJUSTMENTS		0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
6/26/2020 1:35 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	7,975,194		7,975,194	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)	7,975,194		7,975,194	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	7,975,194		7,975,194	17.00
18.00	Ancillary services	2,743,538	31,795,456	34,538,994	18.00
19.00	Outpatient services	408,743	36,375,629	36,784,372	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
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	Other Patient Service Revenue	3,038,753	259,915	3,298,668	27.00
27.02	Capitation Revenue - Net	75,326,546	0	75,326,546	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	89,492,774	68,431,000	157,923,774	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		76,138,224		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)		76,138,224		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0300

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

Worksheet G-3

Date/Time Prepared:
6/26/2020 1:35 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	157,923,774	1.00
2.00	Less contractual allowances and discounts on patients' accounts	82,597,228	2.00
3.00	Net patient revenues (line 1 minus line 2)	75,326,546	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	76,138,224	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-811,678	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,064	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	125,065	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	192,949	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	534,210	23.00
24.00	Other	121,783	24.00
25.00	Total other income (sum of lines 6-24)	975,071	25.00
26.00	Total (line 5 plus line 25)	163,393	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)	163,393	29.00

CALCULATION OF CAPITAL PAYMENT

Provider CCN: 14-0300

Period:
From 12/01/2018
To 11/30/2019Worksheet L
Parts I-III
Date/Time Prepared:
6/26/2020 1:35 pm

		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		35,787	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		0	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		9.19	3.00
4.00	Number of interns & residents (see instructions)		3.13	4.00
5.00	Indirect medical education percentage (see instructions)		10.09	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)		3,611	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		39,398	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