

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050 EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0124	Period: From 12/01/2019 To 11/30/2020	Worksheet S Parts I-III Date/Time Prepared: 6/29/2021 4:24 pm
--	-----------------------	---	--

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 6/29/2021	Time: 4:24 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by JOHN H. STROGER JR. HOSP OF COOK CTY (14-0124) for the cost reporting period beginning 12/01/2019 and ending 11/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	21,185,335	175,492	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	21,185,335	175,492	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0124		Period: From 12/01/2019 To 11/30/2020		Worksheet S-2 Part I Date/Time Prepared: 6/29/2021 4:24 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 1901 WEST HARRISON STREET			PO Box:				1.00	
2.00	City: CHICAGO			State: IL		Zip Code: 60612-3714		County: COOK	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			JOHN H. STROGER JR. HOSP OF COOK CTY	140124	16974	1	07/01/1966	N P O
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis			JOHN H. STROGER JR. HOSP DIALYSIS	142313	16974		07/01/1973	
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						12/01/2019	11/30/2020	20.00
21.00	Type of Control (see instructions)						9		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N		23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
				1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			18,032	0	0	0	25,163	0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet S-2
Part I
Date/Time Prepared:
6/29/2021 4:24 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
						Urban/Rural S	Date of Geogr	
						1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
						Beginning:	Ending:	
						1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
						Y/N	Y/N	
						1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	Y	40.00
						V	XVIII	XIX
						1.00	2.00	3.00
<u>Prospective Payment System (PPS)-Capital</u>								
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	Y	N
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
<u>Teaching Hospitals</u>								
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					Y	Y	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		
					NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
					1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.				Y	Y		60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)					23.00	1	60.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet S-2
Part I
Date/Time Prepared:
6/29/2021 4:24 pm

	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00		2.00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet S-2
Part I
Date/Time Prepared:
6/29/2021 4:24 pm

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

6/29/2021 4:24 pm Y:\15601 - John H Stroger Jr. Hospital of Cook County\300 - Medicare Cost Report\20201130\HFS Files\2020 Stoger

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0124	Period: From 12/01/2019 To 11/30/2020	Worksheet S-2 Part I Date/Time Prepared: 6/29/2021 4:24 pm	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				
		1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0124	Period: From 12/01/2019 To 11/30/2020	Worksheet S-2 Part I Date/Time Prepared: 6/29/2021 4:24 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	2,511,193	48,050,000	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB2320	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0124		Period: From 12/01/2019 To 11/30/2020		Worksheet S-2 Part I Date/Time Prepared: 6/29/2021 4:24 pm	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name: COOK COUNTY	Contractor's Name: COOK COUNTY		Contractor's Number: 00131				141.00	
142.00	Street: 1340 S. DAMEN AVENUE	PO Box: SUITE 215						142.00	
143.00	City: CHICAGO	State: IL		Zip Code: 60608				143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							N	Y
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.							N	
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	157.00		
158.00	SUBPROVIDER						158.00		
159.00	SNF	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	161.00		
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							9.99	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0124		Period: From 12/01/2019 To 11/30/2020		Worksheet S-2 Part II Date/Time Prepared: 6/29/2021 4:24 pm	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			Y			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			Y			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			Y			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			Y			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N			14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N			15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			Y	06/02/2021	Y	06/02/2021
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0124	Period: From 12/01/2019 To 11/30/2020	Worksheet S-2 Part II Date/Time Prepared: 6/29/2021 4:24 pm
		Description	Y/N	Y/N
		0	1.00	3.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				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.	DAN	ROGERS	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.	3172375500	DANR@BRADLEYCPA.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet S-2
Part II
Date/Time Prepared:
6/29/2021 4:24 pm

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet S-3
Part I
Date/Time Prepared:
6/29/2021 4:24 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	320	117,120	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		320	117,120	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	37	13,542	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT	33.00	6	2,196	0.00	0	10.00
11.00 SURGICAL INTENSIVE CARE UNIT	34.00	14	5,124	0.00	0	11.00
11.01 PEDIATRIC INTENSIVE CARE UNIT	34.01	0	0	0.00	0	11.01
11.02 TRAUMA INTENSIVE CARE UNIT	34.02	12	4,392	0.00	0	11.02
11.03 NEURO INTENSIVE CARE	34.03	10	3,660	0.00	0	11.03
11.04 NEONATAL INTENSIVE CARE UNIT	34.04	52	19,032	0.00	0	11.04
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		451	165,066	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		451				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		9	3,294			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet S-3
Part I
Date/Time Prepared:
6/29/2021 4:24 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)	6,611	12,714	58,822			1.00
2.00	HMO and other (see instructions)	4,670	25,163				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)	6,611	12,714	58,822			7.00
8.00	INTENSIVE CARE UNIT	897	1,874	8,667			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT	144	292	1,352			10.00
11.00	SURGICAL INTENSIVE CARE UNIT	313	644	2,977			11.00
11.01	PEDIATRIC INTENSIVE CARE UNIT	0	0	0			11.01
11.02	TRAUMA INTENSIVE CARE UNIT	219	545	2,519			11.02
11.03	NEURO INTENSIVE CARE	258	429	1,986			11.03
11.04	NEONATAL INTENSIVE CARE UNIT	0	1,204	5,568			11.04
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		330	1,526			13.00
14.00	Total (see instructions)	8,442	18,032	83,417	475.18	4,401.11	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				475.18	4,401.11	27.00
28.00	Observation Bed Days		0	12,813			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	948			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet S-3
Part I
Date/Time Prepared:
6/29/2021 4:24 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,397	3,506	15,808	1.00
2.00 HMO and other (see instructions)			749	2,383		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
11.01 PEDIATRIC INTENSIVE CARE UNIT						11.01
11.02 TRAUMA INTENSIVE CARE UNIT						11.02
11.03 NEURO INTENSIVE CARE						11.03
11.04 NEONATAL INTENSIVE CARE UNIT						11.04
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,397	3,506	15,808	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet S-3
Part II
Date/Time Prepared:
6/29/2021 4:24 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	472,761,104	0	472,761,104	9,154,308.00	51.64
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		2,032,114	0	2,032,114	22,976.00	88.45
4.00	Physician-Part A - Administrative		58,727,524	0	58,727,524	378,013.00	155.36
4.01	Physicians - Part A - Teaching		8,219,321	0	8,219,321	62,982.00	130.50
5.00	Physician and Non Physician-Part B		85,999,018	0	85,999,018	774,482.00	111.04
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	24,590,069	1,688,659	26,278,728	862,787.00	30.46
7.01	Contracted interns and residents (in an approved programs)		498,840	0	498,840	11,980.00	41.64
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		0	920,079	920,079	17,687.00	52.02
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		21,966,398	0	21,966,398	380,648.00	57.71
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		39,032,799	0	39,032,799	922,555.00	42.31
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		149,160,962	0	149,160,962		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		428,077	0	428,077		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		790,445	0	790,445		
22.00	Physician Part A - Administrative		20,088,284	0	20,088,284		
22.01	Physician Part A - Teaching		2,908,583	0	2,908,583		
23.00	Physician Part B		31,545,383	0	31,545,383		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		15,672,011	0	15,672,011		
25.50	Home office wage-related (core)		6,151,859	0	6,151,859		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet S-3
Part II
Date/Time Prepared:
6/29/2021 4:24 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	2,144,220	0	2,144,220	39,006.00	54.97	26.00
27.00	Administrative & General	5.00	25,225,794	-1,422,834	23,802,960	1,040,245.00	22.88	27.00
28.00	Administrative & General under contract (see inst.)		20,448,375	0	20,448,375	386,329.00	52.93	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	15,397,473	0	15,397,473	278,243.00	55.34	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	8,690,858	0	8,690,858	360,564.00	24.10	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	3,778,174	-2,270,373	1,507,801	56,723.00	26.58	34.00
35.00	Dietary under contract (see instructions)		2,559,543	0	2,559,543	111,697.00	22.92	35.00
36.00	Cafeteria	11.00	0	2,270,373	2,270,373	85,410.00	26.58	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	5,470,023	0	5,470,023	88,375.00	61.90	38.00
39.00	Central Services and Supply	14.00	4,070,662	0	4,070,662	151,074.00	26.94	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	3,980,251	0	3,980,251	118,620.00	33.55	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: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet S-3
Part III
Date/Time Prepared:
6/29/2021 4:24 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)	374,429,660	-1,688,659	372,741,001	7,917,127.00	47.08	1.00
2.00	Excluded area salaries (see instructions)	0	920,079	920,079	17,687.00	52.02	2.00
3.00	Subtotal salaries (line 1 minus line 2)	374,429,660	-2,608,738	371,820,922	7,899,440.00	47.07	3.00
4.00	Subtotal other wages & related costs (see inst.)	60,999,197	0	60,999,197	1,303,203.00	46.81	4.00
5.00	Subtotal wage-related costs (see inst.)	175,401,105	0	175,401,105	0.00	47.17	5.00
6.00	Total (sum of lines 3 thru 5)	610,829,962	-2,608,738	608,221,224	9,202,643.00	66.09	6.00
7.00	Total overhead cost (see instructions)	91,765,373	-1,422,834	90,342,539	2,716,286.00	33.26	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet S-3
Part IV
Date/Time Prepared:
6/29/2021 4:24 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)	125,610,719	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)	59,152,231	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	20,575,814	9.00
10.00	Dental, Hearing and Vision Plan	2,879,285	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	887,229	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	3,856,305	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	0	17.00
18.00	Medicare Taxes - Employers Portion Only	6,617,257	18.00
19.00	Unemployment Insurance	164,887	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	850,018	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	220,593,745	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED - MALPRACTICE EXP		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet S-3
Part V
Date/Time Prepared:
6/29/2021 4:24 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	21,966,398	220,593,745	1.00
2.00	Hospital	21,966,398	149,160,962	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			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	71,432,783	18.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

Provider CCN: 14-0124

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

Worksheet S-5

Date/Time Prepared:
6/29/2021 4:24 pm

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

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

Provider CCN: 14-0124

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

Worksheet S-5

Date/Time Prepared:
6/29/2021 4:24 pm

		CCN	Treatments	
		1.00	2.00	
23.00	If line 10.01 is yes, enter in column 1 the CCN for each renal dialysis facility listed on Worksheet S-2, Part I, line 18, and its subscripts. Enter in column 2, the total treatments for each CCN. (see instructions)	142313	6,870	23.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0124	Period: From 12/01/2019 To 11/30/2020	Worksheet S-10 Date/Time Prepared: 6/29/2021 4:24 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)		0.865143	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		97,340,077	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		391,424,572	6.00
7.00	Medicaid cost (line 1 times line 6)		338,638,228	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)		241,298,151	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		2,143,907	9.00
10.00	Stand-alone CHIP charges		3,119,731	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		2,699,013	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		555,106	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)		6,764,375	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		10,249,353	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		8,867,156	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)		2,102,781	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)		243,956,038	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)	262,033,689	7,770,018	269,803,707
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	226,696,612	7,770,018	234,466,630
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	226,696,612	7,770,018	234,466,630
				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)		158,037,847	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		2,635,693	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		4,054,912	27.01
28.00	Non-Medicare bad debt expense (see instructions)		153,982,935	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		134,636,477	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		369,103,107	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		613,059,145	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0124

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

Worksheet A

Date/Time Prepared:
6/29/2021 4:24 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		16,359,576	16,359,576	337,134	16,696,710	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		6,492,207	6,492,207	0	6,492,207	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,144,220	93,026,165	95,170,385	3,342,414	98,512,799	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	25,225,794	167,263,069	192,488,863	-5,102,382	187,386,481	5.00
7.00	00700	OPERATION OF PLANT	15,397,473	25,852,817	41,250,290	0	41,250,290	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,843,969	1,843,969	0	1,843,969	8.00
9.00	00900	HOUSEKEEPING	8,690,858	1,590,860	10,281,718	0	10,281,718	9.00
10.00	01000	DIETARY	3,778,174	2,790,187	6,568,361	-3,947,047	2,621,314	10.00
11.00	01100	CAFETERIA	0	0	0	3,947,047	3,947,047	11.00
13.00	01300	NURSING ADMINISTRATION	5,470,023	4,137,160	9,607,183	0	9,607,183	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,070,662	13,605,145	17,675,807	0	17,675,807	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,980,251	3,015,344	6,995,595	0	6,995,595	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	24,590,069	508,743	25,098,812	1,688,659	26,787,471	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	2,198,609	857,162	3,055,771	8,707,083	11,762,854	22.00
23.00	02300	ALLIED HEALTH	0	0	0	208,104	208,104	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	54,296,370	5,162,894	59,459,264	-767,378	58,691,886	30.00
31.00	03100	INTENSIVE CARE UNIT	7,020,245	0	7,020,245	308,260	7,328,505	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	3,250,714	0	3,250,714	33,310	3,284,024	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	4,089,588	0	4,089,588	26,168	4,115,756	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	6,734,568	421,380	7,155,948	341,128	7,497,076	34.02
34.03	02400	NEURO INTENSIVE CARE	1,957,781	0	1,957,781	46,854	2,004,635	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	6,123,317	0	6,123,317	3,467	6,126,784	34.04
43.00	04300	NURSERY	2,398,485	3,883	2,402,368	0	2,402,368	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	25,699,010	13,940,465	39,639,475	-636,954	39,002,521	50.00
51.00	05100	RECOVERY ROOM	3,287,206	0	3,287,206	0	3,287,206	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,864,719	0	2,864,719	79,602	2,944,321	52.00
53.00	05300	ANESTHESIOLOGY	11,831,707	728,633	12,560,340	-964,300	11,596,040	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,573,897	9,937,510	30,511,407	-581,004	29,930,403	54.00
60.00	06000	LABORATORY	12,858,614	11,560,566	24,419,180	-99,503	24,319,677	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	922,409	3,103,843	4,026,252	0	4,026,252	62.00
65.00	06500	RESPIRATORY THERAPY	3,694,405	1,484,965	5,179,370	0	5,179,370	65.00
66.00	06600	PHYSICAL THERAPY	2,881,588	218,104	3,099,692	0	3,099,692	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,041,125	51,062	1,092,187	0	1,092,187	67.00
68.00	06800	SPEECH PATHOLOGY	485,657	80,431	566,088	0	566,088	68.00
69.00	06900	ELECTROCARDIOLOGY	2,096,101	3,843,219	5,939,320	-79,864	5,859,456	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	19,174,100	19,174,100	-5,061,487	14,112,613	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,061,487	5,061,487	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,794,144	87,030,377	108,824,521	-214,101	108,610,420	73.00
74.00	07400	RENAL DIALYSIS	4,041,229	110,257	4,151,486	0	4,151,486	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	146,099,876	12,824,631	158,924,507	-6,674,451	152,250,056	90.00
91.00	09100	EMERGENCY	31,172,216	335,864	31,508,080	-714,221	30,793,859	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	472,761,104	507,354,588	980,115,692	-711,975	979,403,717	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	0	0	0	711,975	711,975	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	472,761,104	507,354,588	980,115,692	0	980,115,692	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0124

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

Worksheet A

Date/Time Prepared:
6/29/2021 4:24 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	33,783,716	50,480,426	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	10,082,718	16,574,925	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	124,814,903	223,327,702	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	53,080,908	240,467,389	5.00
7.00	00700	OPERATION OF PLANT	-2,623,054	38,627,236	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,843,969	8.00
9.00	00900	HOUSEKEEPING	0	10,281,718	9.00
10.00	01000	DIETARY	0	2,621,314	10.00
11.00	01100	CAFETERIA	0	3,947,047	11.00
13.00	01300	NURSING ADMINISTRATION	539,470	10,146,653	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	17,675,807	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-90,576	6,905,019	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	26,787,471	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	-6,718,345	5,044,509	22.00
23.00	02300	ALLIED HEALTH	0	208,104	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-17,282,419	41,409,467	30.00
31.00	03100	INTENSIVE CARE UNIT	-256,589	7,071,916	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	3,284,024	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	-694,860	3,420,896	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	-743,853	6,753,223	34.02
34.03	02400	NEURO INTENSIVE CARE	0	2,004,635	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	-378,705	5,748,079	34.04
43.00	04300	NURSERY	0	2,402,368	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-5,957,962	33,044,559	50.00
51.00	05100	RECOVERY ROOM	-364,366	2,922,840	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-139,937	2,804,384	52.00
53.00	05300	ANESTHESIOLOGY	-7,004,114	4,591,926	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-4,195,143	25,735,260	54.00
60.00	06000	LABORATORY	-2,520,541	21,799,136	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	4,026,252	62.00
65.00	06500	RESPIRATORY THERAPY	-460,760	4,718,610	65.00
66.00	06600	PHYSICAL THERAPY	0	3,099,692	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,092,187	67.00
68.00	06800	SPEECH PATHOLOGY	0	566,088	68.00
69.00	06900	ELECTROCARDIOLOGY	-300,538	5,558,918	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	14,112,613	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,061,487	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	304,496	108,914,916	73.00
74.00	07400	RENAL DIALYSIS	-1,526,523	2,624,963	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-40,911,730	111,338,326	90.00
91.00	09100	EMERGENCY	-6,079,602	24,714,257	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	124,356,594	1,103,760,311	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.03	19003	SPECIAL FUNDS	0	711,975	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	190.04
194.00	07950	COUNTYCARE	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	124,356,594	1,104,472,286	200.00

RECLASSIFICATIONS

Provider CCN: 14-0124

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

Worksheet A-6

Date/Time Prepared:
6/29/2021 4:24 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - Fringe Benefits to EHW					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,342,414		1.00
	TOTALS		0	3,342,414		
	C - Sal of Non Residents					
1.00	I&R SERVICES-OTHER PRGM	22.00	962,777			1.00
	COSTS APPRV		962,777	0		
	D - Peds Algy & Psych to Inp					
1.00	ADULTS & PEDIATRICS	30.00	334,213			1.00
			334,213	0		
	E - Registry and In-House Nsg					
1.00	INTENSIVE CARE UNIT	31.00	132,298	175,962		1.00
2.00	BURN INTENSIVE CARE UNIT	33.00	5,861	27,449		2.00
3.00	SURGICAL INTENSIVE CARE UNIT	34.00	5,861	20,307		3.00
4.00	TRAUMA INTENSIVE CARE UNIT	34.02	15,787	325,341		4.00
5.00	NEURO INTENSIVE CARE	34.03	2,647	44,207		5.00
6.00	DELIVERY ROOM & LABOR ROOM	52.00	11,486	68,116		6.00
7.00	EMERGENCY	91.00		2,311		7.00
8.00	CLINIC	90.00		4,623		8.00
9.00	NEONATAL INTENSIVE CARE UNIT	34.04		3,467		9.00
			173,940	671,783		
	F - Dietary/Cafeteria					
1.00	CAFETERIA	11.00	2,270,373	1,676,674		1.00
			2,270,373	1,676,674		
	G - Hektoen Cost to Research					
1.00	SPECIAL FUNDS	190.03	711,975			1.00
2.00						2.00
3.00						3.00
4.00						4.00
5.00			711,975	0		5.00
	H - Implants					
1.00	IMPL. DEV. CHARGED TO	72.00		5,061,487		1.00
	PATIENTS					
			0	5,061,487		
	I - HBP Teaching Time					
1.00	I&R SERVICES-OTHER PRGM	22.00	8,219,320			1.00
2.00	COSTS APPRV					2.00
3.00						3.00
4.00						4.00
5.00						5.00
6.00						6.00
7.00			8,219,320	0		7.00
	K - Insurance Reclass					
1.00	CAP REL COSTS-BLDG & FIXT	1.00		337,134		1.00
			0	337,134		
	L - Pharmacy School					
1.00	ALLIED HEALTH	23.00	208,104			1.00
			208,104	0		
	M - Medical Director					
1.00	ADMINISTRATIVE & GENERAL	5.00	475,014			1.00
			475,014	0		
	N - I&R Salaries					
1.00	I&R SERVICES-SALARY &	21.00	2,651,436			1.00
2.00	FRINGES APPRV					2.00
3.00						3.00
4.00						4.00
			2,651,436	0		
	O - TRANSPORTER SALARIES					
1.00	ADULTS & PEDIATRICS	30.00	1,858,845	0		1.00
	TOTALS		1,858,845	0		
500.00	Grand Total: Increases		17,865,997	11,089,492		500.00

RECLASSIFICATIONS

Provider CCN: 14-0124

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

Worksheet A-6

Date/Time Prepared:
6/29/2021 4:24 pm

	Decreases							6/29/2021 4:24 pm
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
	A - Fringe Benefits to EHW							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,342,414	0			1.00
	TOTALS		0	3,342,414				
	C - Sal of Non Residents							
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	962,777					1.00
			962,777	0				
	D - Peds Algy & Psych to Inp							
1.00	CLINIC	90.00	334,213					1.00
			334,213	0				
	E - Registry and In-House Nsg							
1.00	ADULTS & PEDIATRICS	30.00	173,940	671,783				1.00
2.00								2.00
3.00								3.00
4.00								4.00
5.00								5.00
6.00								6.00
7.00								7.00
8.00								8.00
9.00			173,940	671,783				9.00
	F - Dietary/Cafeteria							
1.00	DIETARY	10.00	2,270,373	1,676,674				1.00
			2,270,373	1,676,674				
	G - Hektoen Cost to Research							
1.00	ADMINISTRATIVE & GENERAL	5.00	39,003					1.00
2.00	ADULTS & PEDIATRICS	30.00	615,735					2.00
3.00	ANESTHESIOLOGY	53.00	17,702					3.00
4.00	CLINIC	90.00	33,538					4.00
5.00	DRUGS CHARGED TO PATIENTS	73.00	5,997					5.00
			711,975	0				
	H - Implants							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00		5,061,487				1.00
			0	5,061,487				
	I - HBP Teaching Time							
1.00	ADULTS & PEDIATRICS	30.00	1,498,978					1.00
2.00	OPERATING ROOM	50.00	636,954					2.00
3.00	ANESTHESIOLOGY	53.00	946,598					3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	555,138					4.00
5.00	LABORATORY	60.00	99,503					5.00
6.00	CLINIC	90.00	3,874,776					6.00
7.00	EMERGENCY	91.00	607,373					7.00
			8,219,320	0				
	K - Insurance Reclass							
1.00	ADMINISTRATIVE & GENERAL	5.00		337,134	12			1.00
			0	337,134				
	L - Pharmacy School							
1.00	DRUGS CHARGED TO PATIENTS	73.00	208,104					1.00
			208,104	0				
	M - Medical Director							
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	475,014					1.00
			475,014	0				
	N - I&R Salaries							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	25,866					1.00
2.00	ELECTROCARDIOLOGY	69.00	79,864					2.00
3.00	CLINIC	90.00	2,436,547					3.00
4.00	EMERGENCY	91.00	109,159					4.00
			2,651,436	0				
	O - TRANSPORTER SALARIES							
1.00	ADMINISTRATIVE & GENERAL	5.00	1,858,845	0	0			1.00
	TOTALS		1,858,845	0				
500.00	Grand Total: Decreases		17,865,997	11,089,492				500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet A-7
Part I
Date/Time Prepared:
6/29/2021 4:24 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	990,911	0	0	0	0	1.00
2.00	Land Improvements	2,631,393	0	0	0	0	2.00
3.00	Buildings and Fixtures	800,847,880	41,615,308	0	41,615,308	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	13,729,987	108,450	0	108,450	0	5.00
6.00	Movable Equipment	159,879,684	17,631,516	0	17,631,516	0	6.00
7.00	HIT designated Assets	10,641,119	0	0	0	10,641,119	7.00
8.00	Subtotal (sum of lines 1-7)	988,720,974	59,355,274	0	59,355,274	10,641,119	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	988,720,974	59,355,274	0	59,355,274	10,641,119	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	990,911	0				1.00
2.00	Land Improvements	2,631,393	0				2.00
3.00	Buildings and Fixtures	842,463,188	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	13,838,437	0				5.00
6.00	Movable Equipment	177,511,200	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	1,037,435,129	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	1,037,435,129	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet A-7
Part II
Date/Time Prepared:
6/29/2021 4:24 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	16,128,117	0	231,459	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,492,207	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	22,620,324	0	231,459	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
		PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2					
1.00	CAP REL COSTS-BLDG & FIXT	0	16,359,576				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	6,492,207				2.00
3.00	Total (sum of lines 1-2)	0	22,851,783				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet A-7
Part III
Date/Time Prepared:
6/29/2021 4:24 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	859,923,928	0	859,923,928	0.828894	0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	177,511,200	0	177,511,200	0.171106	0	2.00	
3.00	Total (sum of lines 1-2)	1,037,435,128	0	1,037,435,128	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	15,464,933	0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	6,492,207	0	2.00	
3.00	Total (sum of lines 1-2)	0	0	0	21,957,140	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	34,678,359	337,134	0	0	50,480,426	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	10,082,718	0	0	0	16,574,925	2.00	
3.00	Total (sum of lines 1-2)	44,761,077	337,134	0	0	67,055,351	3.00	

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0124

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

Worksheet A-8

Date/Time Prepared:
6/29/2021 4:24 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	-150,824	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	-2,623,054	OPERATION OF PLANT	7.00		9.00
11.00	Provider-based physician adjustment	A-8-2	-78,001,561				10.00
12.00	Sale of scrap, waste, etc. (chapter 23)						
13.00	Related organization transactions (chapter 10)	A-8-1	44,449,889				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	-337,712	DRUGS CHARGED TO PATIENTS	73.00		17.00
19.00	Sale of medical records and abstracts	B	-90,576	MEDICAL RECORDS & LIBRARY	16.00		18.00
20.00	Nursing and allied health education (tuition, fees, books, etc.)						
21.00	Vending machines						
22.00	Income from imposition of interest, finance or penalty charges (chapter 21)						
23.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments						
24.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		RESPIRATORY THERAPY	65.00		23.00
25.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY	66.00		24.00
26.00	Utilization review - physicians' compensation (chapter 21)			*** Cost Center Deleted ***	114.00		25.00
27.00	Depreciation - CAP REL COSTS-BLDG & FIXT						
28.00	Depreciation - CAP REL COSTS-MVBLE EQUIP						
29.00	Non-physician Anesthetist			*** Cost Center Deleted ***	19.00		28.00
30.00	Physicians' assistant						
30.99	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67.00		30.00
31.00	Hospice (non-distinct) (see instructions)						
31.99	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		ADULTS & PEDIATRICS	30.00		30.99
32.00	CAH HIT Adjustment for Depreciation and Interest						
33.00	Miscellaneous Income	B	-876,853	ADMINISTRATIVE & GENERAL	5.00		33.00

6/29/2021 4:24 pm Y:\15601 - John H Stroger Jr. Hospital of Cook County\300 - Medicare Cost Report\20201130\HFS Files\2020 Stoger

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0124

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

Worksheet A-8

Date/Time Prepared:
6/29/2021 4:24 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	Residency Program Reimbursement	B	-4,903,203	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	33.01
33.02	Miscellaneous Income	B	-8,643	TRAUMA INTENSIVE CARE UNIT	34.02	0	33.02
33.03	County Adj for Hospital Bond Int.	A	34,597,724	CAP REL COSTS-BLDG & FIXT	1.00	11	33.03
33.04	County Adj for Hospital Bond Int.	A	10,082,718	CAP REL COSTS-MVBLE EQUIP	2.00	11	33.04
33.05	County Adj for Hospital Bond Int.	A	8,585,337	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	Reserve for Claims	A	2,037,708	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.06
33.07	CRNA Costs	A	-2,032,114	ANESTHESIOLOGY	53.00	0	33.07
33.08	IHA Lobbying	A	-102,039	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	Non-physician Part B	A	-263,415	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.09
33.10	Non-physician Part B	A	-89,395	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	Non-physician Part B	A	-1,801,017	ADULTS & PEDIATRICS	30.00	0	33.11
33.12	Non-physician Part B	A	-123,541	SURGICAL INTENSIVE CARE UNIT	34.00	0	33.12
33.13	Non-physician Part B	A	-213,634	NEONATAL INTENSIVE CARE UNIT	34.04	0	33.13
33.14	Non-physician Part B	A	-434,109	OPERATING ROOM	50.00	0	33.14
33.15	Non-physician Part B	A	-139,937	DELIVERY ROOM & LABOR ROOM	52.00	0	33.15
33.16	Non-physician Part B	A	-273,429	LABORATORY	60.00	0	33.16
33.17	Non-physician Part B	A	-236,245	ELECTROCARDIOLOGY	69.00	0	33.17
33.18	Non-physician Part B	A	-6,619,054	CLINIC	90.00	0	33.18
33.19	Non-physician Part B	A	-1,147,995	EMERGENCY	91.00	0	33.19
33.20	Oak Forest Vacant Space	A	-663,184	CAP REL COSTS-BLDG & FIXT	1.00	9	33.20
33.21	Pension Adjustment	A	120,419,375	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.21
33.22	Non-physician Part B	A	-266,420	RENAL DIALYSIS	74.00	0	33.22
33.23	ADDITIONAL INTEREST	A	5,581,797	ADMINISTRATIVE & GENERAL	5.00	0	33.23
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		124,356,594				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0124

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

Worksheet A-8-1

Date/Time Prepared:
6/29/2021 4:24 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	System Health & Hospital - H	3,286,150	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	System Health & Hospital - C	3,031,294	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	System Health & Hospital - A	83,478,877	46,528,110	3.00
3.01	13.00	NURSING ADMINISTRATION	System Health & Hospital - N	539,470	0	3.01
3.02	73.00	DRUGS CHARGED TO PATIENTS	System Health & Hospital - P	642,208	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.			90,977,999	46,528,110	5.00

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

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

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

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

6.00	G	Cook County Health & Hospita	100.00	Cook County Health & Hospital System	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:	COUNTY OWNED				100.00

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

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

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

Provider CCN: 14-0124

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

Worksheet A-8-1

Date/Time Prepared:
6/29/2021 4:24 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	3,286,150	0		1.00
2.00	3,031,294	0		2.00
3.00	36,950,767	0		3.00
3.01	539,470	0		3.01
3.02	642,208	0		3.02
4.00	0	0		4.00
5.00	44,449,889			5.00

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

Related Organization(s) and/or Home Office	
Type of Business	
6.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00	Government		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0124

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

Worksheet A-8-2

Date/Time Prepared:
6/29/2021 4:24 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	664,915	664,915	0	0	0	1.00
2.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	8,219,321	0	8,219,321	211,500	62,982	2.00
3.00	30.00	ADULTS & PEDIATRICS	17,975,642	15,050,218	2,611,122	179,000	23,370	3.00
4.00	31.00	INTENSIVE CARE UNIT	256,589	256,589	0	0	0	4.00
5.00	34.00	SURGICAL INTENSIVE CARE UNIT	571,319	571,319	0	0	0	5.00
6.00	34.02	TRAUMA INTENSIVE CARE UNIT	735,210	735,210	0	0	0	6.00
7.00	34.04	NEONATAL INTENSIVE CARE UNIT	165,071	165,071	0	0	0	7.00
8.00	50.00	OPERATING ROOM	6,862,031	5,443,659	1,359,273	246,400	9,155	8.00
9.00	51.00	RECOVERY ROOM	364,366	364,366	0	0	0	9.00
10.00	53.00	ANESTHESIOLOGY	5,942,533	4,154,515	1,086,835	239,400	6,563	10.00
11.00	54.00	RADIOLOGY-DIAGNOSTIC	5,267,908	4,098,574	1,169,334	271,900	6,518	11.00
12.00	60.00	LABORATORY	2,429,534	2,247,112	182,422	260,300	1,542	12.00
13.00	65.00	RESPIRATORY THERAPY	460,760	460,760	0	0	0	13.00
14.00	69.00	ELECTROCARDIOLOGY	64,293	64,293	0	0	0	14.00
15.00	74.00	RENAL DIALYSIS	1,260,103	1,260,103	0	0	0	15.00
16.00	90.00	CLINIC	44,323,234	31,594,330	11,475,299	179,000	91,795	16.00
17.00	91.00	EMERGENCY	6,509,457	4,641,124	1,577,850	246,400	12,027	17.00
200.00			102,072,286	71,772,158	27,681,456		213,952	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	113,544	1.00
2.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	6,404,179	320,209	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	2,011,168	100,558	0	0	3,325,590	3.00
4.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	43,816	4.00
5.00	34.00	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	97,561	5.00
6.00	34.02	TRAUMA INTENSIVE CARE UNIT	0	0	0	0	125,548	6.00
7.00	34.04	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	28,188	7.00
8.00	50.00	OPERATING ROOM	1,084,515	54,226	0	0	1,280,567	8.00
9.00	51.00	RECOVERY ROOM	0	0	0	0	62,221	9.00
10.00	53.00	ANESTHESIOLOGY	755,376	37,769	0	0	1,176,425	10.00
11.00	54.00	RADIOLOGY-DIAGNOSTIC	852,041	42,602	0	0	994,374	11.00
12.00	60.00	LABORATORY	192,972	9,649	0	0	431,872	12.00
13.00	65.00	RESPIRATORY THERAPY	0	0	0	0	78,682	13.00
14.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	10,979	14.00
15.00	74.00	RENAL DIALYSIS	0	0	0	0	215,182	15.00
16.00	90.00	CLINIC	7,899,666	394,983	0	0	8,230,549	16.00
17.00	91.00	EMERGENCY	1,424,737	71,237	0	0	1,215,308	17.00
200.00			20,624,654	1,031,233	0	0	17,430,406	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	664,915		1.00
2.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	0	6,404,179	1,815,142	1,815,142		2.00
3.00	30.00	ADULTS & PEDIATRICS	483,072	2,494,240	116,882	15,481,402		3.00
4.00	31.00	INTENSIVE CARE UNIT	0	0	0	256,589		4.00
5.00	34.00	SURGICAL INTENSIVE CARE UNIT	0	0	0	571,319		5.00
6.00	34.02	TRAUMA INTENSIVE CARE UNIT	0	0	0	735,210		6.00
7.00	34.04	NEONATAL INTENSIVE CARE UNIT	0	0	0	165,071		7.00
8.00	50.00	OPERATING ROOM	253,663	1,338,178	21,095	5,523,853		8.00
9.00	51.00	RECOVERY ROOM	0	0	0	364,366		9.00
10.00	53.00	ANESTHESIOLOGY	215,157	970,533	116,302	4,972,000		10.00
11.00	54.00	RADIOLOGY-DIAGNOSTIC	220,724	1,072,765	96,569	4,195,143		11.00
12.00	60.00	LABORATORY	32,427	225,399	0	2,247,112		12.00
13.00	65.00	RESPIRATORY THERAPY	0	0	0	460,760		13.00
14.00	69.00	ELECTROCARDIOLOGY	0	0	0	64,293		14.00
15.00	74.00	RENAL DIALYSIS	0	0	0	1,260,103		15.00
16.00	90.00	CLINIC	2,130,892	10,030,558	1,444,741	34,292,676		16.00
17.00	91.00	EMERGENCY	294,583	1,719,320	0	4,931,607		17.00
200.00			3,630,518	24,255,172	3,610,731	78,001,561		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet B
Part I
Date/Time Prepared:
6/29/2021 4:24 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
Net Expenses for Cost Allocation (from Wkst A col. 7)							
0			1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	50,480,426	50,480,426			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	16,574,925	16,574,925			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	223,327,702	405,668	33,058	223,766,428	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	240,467,389	7,551,163	2,629,014	11,317,712	5.00
7.00	00700	OPERATION OF PLANT	38,627,236	18,029,420	800,683	7,321,113	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,843,969	371,700	339	0	8.00
9.00	00900	HOUSEKEEPING	10,281,718	398,183	5,151	4,132,286	9.00
10.00	01000	DIETARY	2,621,314	21,352	849	716,922	10.00
11.00	01100	CAFETERIA	3,947,047	892,121	25,179	1,079,506	11.00
13.00	01300	NURSING ADMINISTRATION	10,146,653	242,888	236,396	2,600,859	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	17,675,807	1,406,246	329,168	1,935,498	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,905,019	637,593	1,834	1,892,510	16.00
17.00	01700	SOCIAL SERVICE	0	76,715	331	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	26,787,471	22,031	2,129	12,494,878	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	5,044,509	0	0	5,185,384	22.00
23.00	02300	ALLIED HEALTH	208,104	2,650	0	98,948	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	41,409,467	5,854,342	4,171,660	25,771,113	30.00
31.00	03100	INTENSIVE CARE UNIT	7,071,916	594,783	0	3,400,855	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	3,284,024	126,967	279	1,548,420	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	3,420,896	200,056	0	1,947,284	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	6,753,223	480,983	404,509	3,209,625	34.02
34.03	02400	NEURO INTENSIVE CARE	2,004,635	100,505	0	932,135	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	5,748,079	256,288	31,669	2,911,484	34.04
43.00	04300	NURSERY	2,402,368	183,348	0	1,140,420	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	33,044,559	1,467,524	4,122,889	11,916,381	50.00
51.00	05100	RECOVERY ROOM	2,922,840	283,174	2,189	1,562,984	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,804,384	280,566	0	1,367,564	52.00
53.00	05300	ANESTHESIOLOGY	4,591,926	97,855	783,368	5,167,180	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,735,260	1,992,102	210,234	9,506,121	54.00
60.00	06000	LABORATORY	21,799,136	1,631,195	462,235	6,066,638	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	4,026,252	58,480	5,894	438,582	62.00
65.00	06500	RESPIRATORY THERAPY	4,718,610	116,790	309,600	1,756,597	65.00
66.00	06600	PHYSICAL THERAPY	3,099,692	97,749	3,726	1,370,123	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,092,187	94,017	0	495,029	67.00
68.00	06800	SPEECH PATHOLOGY	566,088	48,471	8,661	230,918	68.00
69.00	06900	ELECTROCARDIOLOGY	5,558,918	450,768	1,017,577	958,670	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,112,613	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,061,487	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	108,914,916	243,481	26,839	10,260,771	73.00
74.00	07400	RENAL DIALYSIS	2,624,963	49,320	20,009	1,921,503	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	111,338,326	3,998,495	736,734	66,290,973	90.00
91.00	09100	EMERGENCY	24,714,257	1,529,884	192,722	14,480,916	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,103,760,311	50,294,873	16,574,925	223,427,902	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	711,975	130,975	0	338,526	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	190.04
194.00	07950	COUNTYCARE	0	54,578	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,104,472,286	50,480,426	16,574,925	223,766,428	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet B
Part I
Date/Time Prepared:
6/29/2021 4:24 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	261,965,278					5.00
7.00	00700	OPERATION OF PLANT	20,141,888	84,920,340				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	689,034	1,288,668	4,193,710			8.00
9.00	00900	HOUSEKEEPING	4,607,229	1,380,484	0	20,805,051		9.00
10.00	01000	DIETARY	1,044,877	74,027	0	18,725	4,498,066	10.00
11.00	01100	CAFETERIA	1,848,152	3,092,950	0	782,347	0	11.00
13.00	01300	NURSING ADMINISTRATION	4,112,674	842,082	0	213,001	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,637,442	4,875,399	0	1,233,209	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,934,280	2,210,510	0	559,138	0	16.00
17.00	01700	SOCIAL SERVICE	23,956	265,967	0	67,275	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	12,221,769	76,379	0	19,320	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	3,180,832	0	0	0	0	22.00
23.00	02300	ALLIED HEALTH	96,297	9,189	0	2,324	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	24,006,229	20,296,772	1,149,467	5,133,972	2,079,078	30.00
31.00	03100	INTENSIVE CARE UNIT	3,441,290	2,062,089	169,344	521,596	161,526	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	1,542,141	440,191	128,392	111,344	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,731,359	693,587	173,458	175,440	59,391	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	3,373,129	1,667,549	191,838	421,799	0	34.02
34.03	02400	NEURO INTENSIVE CARE	944,395	348,448	16,004	88,138	30,000	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	2,782,097	888,541	152,315	224,752	0	34.04
43.00	04300	NURSERY	1,158,586	635,659	53,477	160,787	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	15,718,185	5,087,849	583,551	1,286,947	28,781	50.00
51.00	05100	RECOVERY ROOM	1,483,529	981,755	185,765	248,330	49,086	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,384,442	972,713	229,416	246,043	46,738	52.00
53.00	05300	ANESTHESIOLOGY	3,308,451	339,259	29,637	85,814	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,642,562	6,906,539	428,537	1,746,977	65,397	54.00
60.00	06000	LABORATORY	9,315,365	5,655,289	0	1,430,479	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,408,289	202,746	0	51,284	0	62.00
65.00	06500	RESPIRATORY THERAPY	2,145,948	404,905	0	102,419	0	65.00
66.00	06600	PHYSICAL THERAPY	1,421,374	338,891	33,715	85,721	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	522,754	325,953	0	82,448	0	67.00
68.00	06800	SPEECH PATHOLOGY	265,581	168,049	0	42,507	6,890	68.00
69.00	06900	ELECTROCARDIOLOGY	2,483,106	1,562,795	46,465	395,302	41,982	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,388,105	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,573,793	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,139,944	844,140	0	213,521	0	73.00
74.00	07400	RENAL DIALYSIS	1,435,212	170,989	0	43,251	11,128	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	56,703,880	13,862,625	27,670	3,506,486	606,836	90.00
91.00	09100	EMERGENCY	12,722,770	5,304,048	594,659	1,341,634	1,311,233	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	261,580,946	84,277,036	4,193,710	20,642,330	4,498,066	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	367,362	454,084	0	114,859	0	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	16,970	189,220	0	47,862	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	261,965,278	84,920,340	4,193,710	20,805,051	4,498,066	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet B
Part I
Date/Time Prepared:
6/29/2021 4:24 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		11.00	13.00	14.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA	11,667,302				11.00
13.00	01300	NURSING ADMINISTRATION	141,360	18,535,913			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	241,650	554,674	34,889,093		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	189,739	428,926	0	15,759,549	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,380,070	38,104	489	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	167,610	77,360	2,675	0	22.00
23.00	02300	ALLIED HEALTH	14,909	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,512,218	2,464,778	4,022	2,244,868	30.00
31.00	03100	INTENSIVE CARE UNIT	249,765	553,669	0	298,723	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	97,269	223,355	0	39,844	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	101,028	199,903	0	100,707	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	154,966	292,026	232	95,487	34.02
34.03	02400	NEURO INTENSIVE CARE	64,991	149,336	0	61,295	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	154,246	332,537	0	158,145	34.04
43.00	04300	NURSERY	76,993	177,157	1,086	59,301	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	569,507	1,043,750	2,765,424	1,970,948	50.00
51.00	05100	RECOVERY ROOM	97,304	211,106	0	166,573	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	89,037	203,186	0	22,925	52.00
53.00	05300	ANESTHESIOLOGY	132,609	142,785	103,408	715,524	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	498,970	935,006	401,634	2,066,660	54.00
60.00	06000	LABORATORY	413,709	830,049	1,526,340	1,775,262	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	27,757	63,868	842,455	161,672	62.00
65.00	06500	RESPIRATORY THERAPY	141,437	302,475	281,709	227,594	65.00
66.00	06600	PHYSICAL THERAPY	102,680	228,224	26,268	89,498	66.00
67.00	06700	OCCUPATIONAL THERAPY	43,261	99,447	1,695	37,313	67.00
68.00	06800	SPEECH PATHOLOGY	17,537	40,353	41	17,137	68.00
69.00	06900	ELECTROCARDIOLOGY	68,811	148,615	632,240	464,487	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	5,360,791	190,519	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	191,975	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	738,630	1,500,913	22,650,820	2,415,559	73.00
74.00	07400	RENAL DIALYSIS	92,743	140,400	3,157	137,248	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	3,279,866	5,679,439	277,164	1,346,952	90.00
91.00	09100	EMERGENCY	793,248	1,474,472	7,443	703,333	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,653,920	18,535,913	34,889,093	15,759,549	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	13,382	0	0	0	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	190.04
194.00	07950	COUNTYCARE	0	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	11,667,302	18,535,913	34,889,093	15,759,549	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet B
Part I
Date/Time Prepared:
6/29/2021 4:24 pm

Cost Center Description			INTERNS & RESIDENTS		ALLIED HEALTH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	53,042,640					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		13,658,370				22.00
23.00	02300	ALLIED HEALTH			432,421			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,095,417	3,114,547	0	151,444,687	-15,209,964	30.00
31.00	03100	INTENSIVE CARE UNIT	1,869,716	481,448	0	20,887,437	-2,351,164	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	375,276	96,633	0	8,019,470	-471,909	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	545,149	140,375	0	9,496,675	-685,524	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	0	0	0	17,053,408	0	34.02
34.03	02400	NEURO INTENSIVE CARE	83,271	21,442	0	4,852,637	-104,713	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	999,254	257,306	0	14,904,755	-1,256,560	34.04
43.00	04300	NURSERY	308,659	79,479	0	6,437,320	-388,138	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,871,158	2,284,305	0	90,761,758	-11,155,463	50.00
51.00	05100	RECOVERY ROOM	0	0	0	8,194,635	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	707,250	182,115	0	8,536,379	-889,365	52.00
53.00	05300	ANESTHESIOLOGY	3,462,971	891,708	0	19,852,495	-4,354,679	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,227,227	573,506	0	64,936,732	-2,800,733	54.00
60.00	06000	LABORATORY	1,142,481	294,186	0	52,342,364	-1,436,667	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	7,287,279	0	62.00
65.00	06500	RESPIRATORY THERAPY	972,608	250,444	0	11,731,136	-1,223,052	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,897,661	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,794,104	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,412,233	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,418,941	365,374	0	15,614,051	-1,784,315	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	24,052,028	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,827,255	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	113,249	29,161	432,421	185,524,365	-142,410	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	6,666,006	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	8,740,144	2,250,569	0	278,798,947	-10,990,713	90.00
91.00	09100	EMERGENCY	9,109,869	2,345,772	0	76,706,676	-11,455,641	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	53,042,640	13,658,370	432,421	1,102,032,493	-66,701,010	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	0	0	0	2,131,163	0	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	0	0	0	308,630	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	53,042,640	13,658,370	432,421	1,104,472,286	-66,701,010	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet B
Part I
Date/Time Prepared:
6/29/2021 4:24 pm

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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet B
Part II
Date/Time Prepared:
6/29/2021 4:24 pm

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	405,668	33,058	438,726	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	28,438,500	7,551,163	2,629,014	38,618,677	5.00
7.00	00700	OPERATION OF PLANT	0	18,029,420	800,683	18,830,103	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	371,700	339	372,039	8.00
9.00	00900	HOUSEKEEPING	0	398,183	5,151	403,334	9.00
10.00	01000	DIETARY	0	21,352	849	22,201	10.00
11.00	01100	CAFETERIA	0	892,121	25,179	917,300	11.00
13.00	01300	NURSING ADMINISTRATION	0	242,888	236,396	479,284	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	535,856	1,406,246	329,168	2,271,270	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	637,593	1,834	639,427	16.00
17.00	01700	SOCIAL SERVICE	0	76,715	331	77,046	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	22,031	2,129	24,160	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	ALLIED HEALTH	0	2,650	0	2,650	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	5,854,342	4,171,660	10,026,002	30.00
31.00	03100	INTENSIVE CARE UNIT	0	594,783	0	594,783	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	126,967	279	127,246	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	200,056	0	200,056	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	0	480,983	404,509	885,492	34.02
34.03	02400	NEURO INTENSIVE CARE	0	100,505	0	100,505	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	0	256,288	31,669	287,957	34.04
43.00	04300	NURSERY	0	183,348	0	183,348	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,467,524	4,122,889	5,590,413	50.00
51.00	05100	RECOVERY ROOM	0	283,174	2,189	285,363	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	280,566	0	280,566	52.00
53.00	05300	ANESTHESIOLOGY	0	97,855	783,368	881,223	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	328,199	1,992,102	210,234	2,530,535	54.00
60.00	06000	LABORATORY	0	1,631,195	462,235	2,093,430	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	58,480	5,894	64,374	62.00
65.00	06500	RESPIRATORY THERAPY	475,831	116,790	309,600	902,221	65.00
66.00	06600	PHYSICAL THERAPY	0	97,749	3,726	101,475	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	94,017	0	94,017	67.00
68.00	06800	SPEECH PATHOLOGY	0	48,471	8,661	57,132	68.00
69.00	06900	ELECTROCARDIOLOGY	0	450,768	1,017,577	1,468,345	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,599,293	243,481	26,839	1,869,613	73.00
74.00	07400	RENAL DIALYSIS	0	49,320	20,009	69,329	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,270,729	3,998,495	736,734	6,005,958	90.00
91.00	09100	EMERGENCY	0	1,529,884	192,722	1,722,606	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,648,408	50,294,873	16,574,925	99,518,206	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	0	130,975	0	130,975	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	190.04
194.00	07950	COUNTYCARE	0	54,578	0	54,578	194.00
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)	32,648,408	50,480,426	16,574,925	99,703,759	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet B
Part II
Date/Time Prepared:
6/29/2021 4:24 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	38,640,861				5.00
7.00	00700	OPERATION OF PLANT	2,970,999	21,815,452			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	101,635	331,050	804,724		8.00
9.00	00900	HOUSEKEEPING	679,582	354,637	0	1,445,653	9.00
10.00	01000	DIETARY	154,123	19,017	0	1,301	10.00
11.00	01100	CAFETERIA	272,609	794,558	0	54,362	11.00
13.00	01300	NURSING ADMINISTRATION	606,634	216,325	0	14,800	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	979,046	1,252,456	0	85,690	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	432,817	567,865	0	38,852	16.00
17.00	01700	SOCIAL SERVICE	3,534	68,325	0	4,675	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,802,754	19,621	0	1,342	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	469,184	0	0	0	22.00
23.00	02300	ALLIED HEALTH	14,204	2,361	0	162	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,541,003	5,214,103	220,570	356,739	30.00
31.00	03100	INTENSIVE CARE UNIT	507,602	529,736	32,495	36,243	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	227,471	113,082	24,637	7,737	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	255,382	178,178	33,285	12,191	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	497,548	428,382	36,811	29,309	34.02
34.03	02400	NEURO INTENSIVE CARE	139,302	89,514	3,071	6,124	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	410,369	228,260	29,227	15,617	34.04
43.00	04300	NURSERY	170,896	163,297	10,262	11,172	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,318,487	1,307,033	111,977	89,424	50.00
51.00	05100	RECOVERY ROOM	218,826	252,206	35,646	17,255	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	204,210	249,883	44,022	17,096	52.00
53.00	05300	ANESTHESIOLOGY	488,008	87,153	5,687	5,963	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,717,319	1,774,242	82,231	121,390	54.00
60.00	06000	LABORATORY	1,374,049	1,452,805	0	99,398	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	207,728	52,084	0	3,563	62.00
65.00	06500	RESPIRATORY THERAPY	316,535	104,017	0	7,117	65.00
66.00	06600	PHYSICAL THERAPY	209,658	87,059	6,469	5,956	66.00
67.00	06700	OCCUPATIONAL THERAPY	77,108	83,735	0	5,729	67.00
68.00	06800	SPEECH PATHOLOGY	39,174	43,171	0	2,954	68.00
69.00	06900	ELECTROCARDIOLOGY	366,267	401,471	8,916	27,468	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	647,261	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	232,140	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,478,272	216,854	0	14,837	73.00
74.00	07400	RENAL DIALYSIS	211,699	43,926	0	3,005	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	8,364,083	3,561,213	5,310	243,651	90.00
91.00	09100	EMERGENCY	1,876,653	1,362,573	114,108	93,224	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	38,584,171	21,650,192	804,724	1,434,346	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	54,187	116,651	0	7,981	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	190.04
194.00	07950	COUNTYCARE	2,503	48,609	0	3,326	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	38,640,861	21,815,452	804,724	1,445,653	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet B
Part II
Date/Time Prepared:
6/29/2021 4:24 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		11.00	13.00	14.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA	2,040,945				11.00
13.00	01300	NURSING ADMINISTRATION	24,728	1,346,869			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	42,272	40,304	4,674,832		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	33,191	31,167	0	1,747,029	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	241,414	2,769	65	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	29,320	5,621	358	0	22.00
23.00	02300	ALLIED HEALTH	2,608	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	264,530	179,097	539	248,881	30.00
31.00	03100	INTENSIVE CARE UNIT	43,691	40,231	0	33,118	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	17,015	16,230	0	4,417	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	17,673	14,525	0	11,165	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	27,108	21,219	31	10,586	34.02
34.03	02400	NEURO INTENSIVE CARE	11,369	10,851	0	6,796	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	26,982	24,163	0	17,533	34.04
43.00	04300	NURSERY	13,468	12,873	145	6,574	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	99,623	75,842	370,543	218,512	50.00
51.00	05100	RECOVERY ROOM	17,021	15,340	0	18,467	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,575	14,764	0	2,542	52.00
53.00	05300	ANESTHESIOLOGY	23,197	10,375	13,856	79,328	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	87,284	67,940	53,816	229,123	54.00
60.00	06000	LABORATORY	72,370	60,314	204,516	196,817	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	4,855	4,641	112,882	17,924	62.00
65.00	06500	RESPIRATORY THERAPY	24,741	21,979	37,747	25,232	65.00
66.00	06600	PHYSICAL THERAPY	17,962	16,583	3,520	9,922	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,568	7,226	227	4,137	67.00
68.00	06800	SPEECH PATHOLOGY	3,068	2,932	5	1,900	68.00
69.00	06900	ELECTROCARDIOLOGY	12,037	10,799	84,715	51,496	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	718,300	21,122	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	21,284	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	129,208	109,060	3,035,009	267,629	73.00
74.00	07400	RENAL DIALYSIS	16,223	10,202	423	15,216	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	573,741	412,683	37,138	149,332	90.00
91.00	09100	EMERGENCY	138,762	107,139	997	77,976	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,038,604	1,346,869	4,674,832	1,747,029	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	2,341	0	0	0	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	190.04
194.00	07950	COUNTYCARE	0	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,040,945	1,346,869	4,674,832	1,747,029	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet B
Part II
Date/Time Prepared:
6/29/2021 4:24 pm

Cost Center Description			INTERNS & RESIDENTS		ALLIED HEALTH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	2,116,617					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		514,647				22.00
23.00	02300	ALLIED HEALTH			22,179			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				20,241,880	0	30.00
31.00	03100	INTENSIVE CARE UNIT				1,835,467	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT				542,757	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT				731,731	0	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT				0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT				1,945,621	0	34.02
34.03	02400	NEURO INTENSIVE CARE				373,524	0	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT				1,048,659	0	34.04
43.00	04300	NURSERY				574,270	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM				10,206,479	0	50.00
51.00	05100	RECOVERY ROOM				865,349	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM				833,397	0	52.00
53.00	05300	ANESTHESIOLOGY				1,604,918	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				6,685,392	0	54.00
60.00	06000	LABORATORY				5,565,590	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL				468,911	0	62.00
65.00	06500	RESPIRATORY THERAPY				1,443,032	0	65.00
66.00	06600	PHYSICAL THERAPY				461,290	0	66.00
67.00	06700	OCCUPATIONAL THERAPY				280,717	0	67.00
68.00	06800	SPEECH PATHOLOGY				151,092	0	68.00
69.00	06900	ELECTROCARDIOLOGY				2,435,241	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				1,386,683	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				253,424	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				11,140,595	0	73.00
74.00	07400	RENAL DIALYSIS				379,967	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC				19,563,918	0	90.00
91.00	09100	EMERGENCY				5,608,597	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	96,628,501	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				0	0	190.00
190.03	19003	SPECIAL FUNDS				312,799	0	190.03
190.04	19004	SENGSTACKE CLINIC				0	0	190.04
194.00	07950	COUNTYCARE				109,016	0	194.00
200.00		Cross Foot Adjustments	2,116,617	514,647	22,179	2,653,443	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,116,617	514,647	22,179	99,703,759	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet B
Part II
Date/Time Prepared:
6/29/2021 4:24 pm

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0124

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

Worksheet B-1

Date/Time Prepared:
6/29/2021 4:24 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,380,745					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		6,361,062				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	19,132	12,687	470,616,884			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	356,126	1,008,953	23,802,960	-261,965,278	842,507,008	5.00
7.00	00700	OPERATION OF PLANT	850,299	307,283	15,397,473	0	64,778,452	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,530	130	0	0	2,216,008	8.00
9.00	00900	HOUSEKEEPING	18,779	1,977	8,690,858	0	14,817,338	9.00
10.00	01000	DIETARY	1,007	326	1,507,801	0	3,360,437	10.00
11.00	01100	CAFETERIA	42,074	9,663	2,270,373	0	5,943,853	11.00
13.00	01300	NURSING ADMINISTRATION	11,455	90,723	5,470,023	0	13,226,796	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	66,321	126,327	4,070,662	0	21,346,719	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	30,070	704	3,980,251	0	9,436,956	16.00
17.00	01700	SOCIAL SERVICE	3,618	127	0	0	77,046	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,039	817	26,278,728	0	39,306,509	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	10,905,692	0	10,229,893	22.00
23.00	02300	ALLIED HEALTH	125	0	208,104	0	309,702	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	276,101	1,600,983	54,200,775	0	77,206,582	30.00
31.00	03100	INTENSIVE CARE UNIT	28,051	0	7,152,543	0	11,067,554	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	5,988	107	3,256,575	0	4,959,690	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	9,435	0	4,095,449	0	5,568,236	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	22,684	155,241	6,750,355	0	10,848,340	34.02
34.03	02400	NEURO INTENSIVE CARE	4,740	0	1,960,428	0	3,037,275	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	12,087	12,154	6,123,317	0	8,947,520	34.04
43.00	04300	NURSERY	8,647	0	2,398,485	0	3,726,136	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	69,211	1,582,267	25,062,056	0	50,551,353	50.00
51.00	05100	RECOVERY ROOM	13,355	840	3,287,206	0	4,771,187	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,232	0	2,876,205	0	4,452,514	52.00
53.00	05300	ANESTHESIOLOGY	4,615	300,638	10,867,407	0	10,640,329	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	93,951	80,683	19,992,893	0	37,443,717	54.00
60.00	06000	LABORATORY	76,930	177,395	12,759,111	0	29,959,204	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,758	2,262	922,409	0	4,529,208	62.00
65.00	06500	RESPIRATORY THERAPY	5,508	118,817	3,694,405	0	6,901,597	65.00
66.00	06600	PHYSICAL THERAPY	4,610	1,430	2,881,588	0	4,571,290	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,434	0	1,041,125	0	1,681,233	67.00
68.00	06800	SPEECH PATHOLOGY	2,286	3,324	485,657	0	854,138	68.00
69.00	06900	ELECTROCARDIOLOGY	21,259	390,522	2,016,237	0	7,985,933	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	14,112,613	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	5,061,487	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,483	10,300	21,580,043	0	119,446,007	73.00
74.00	07400	RENAL DIALYSIS	2,326	7,679	4,041,229	0	4,615,795	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	188,576	282,741	139,420,802	0	182,364,528	90.00
91.00	09100	EMERGENCY	72,152	73,962	30,455,684	0	40,917,779	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,371,994	6,361,062	469,904,909	-261,965,278	841,270,954	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	6,177	0	711,975	0	1,181,476	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	2,574	0	0	0	54,578	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	50,480,426	16,574,925	223,766,428		261,965,278	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.203626	2.605685	0.475475		0.310935	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			438,726		38,640,861	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000932		0.045864	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0124

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

Worksheet B-1

Date/Time Prepared:
6/29/2021 4:24 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	1,155,188				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,530	2,232,635			8.00
9.00	00900	HOUSEKEEPING	18,779	0	1,118,879		9.00
10.00	01000	DIETARY	1,007	0	1,007	147,535	10.00
11.00	01100	CAFETERIA	42,074	0	42,074	0	11.00
13.00	01300	NURSING ADMINISTRATION	11,455	0	11,455	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	66,321	0	66,321	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	30,070	0	30,070	0	16.00
17.00	01700	SOCIAL SERVICE	3,618	0	3,618	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,039	0	1,039	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	ALLIED HEALTH	125	0	125	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	276,101	611,950	276,101	68,193	30.00
31.00	03100	INTENSIVE CARE UNIT	28,051	90,155	28,051	5,298	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	5,988	68,353	5,988	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	9,435	92,345	9,435	1,948	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	22,684	102,130	22,684	0	34.02
34.03	02400	NEURO INTENSIVE CARE	4,740	8,520	4,740	984	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	12,087	81,089	12,087	0	34.04
43.00	04300	NURSERY	8,647	28,470	8,647	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	69,211	310,669	69,211	944	50.00
51.00	05100	RECOVERY ROOM	13,355	98,897	13,355	1,610	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,232	122,136	13,232	1,533	52.00
53.00	05300	ANESTHESIOLOGY	4,615	15,778	4,615	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	93,951	228,143	93,951	2,145	54.00
60.00	06000	LABORATORY	76,930	0	76,930	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,758	0	2,758	0	62.00
65.00	06500	RESPIRATORY THERAPY	5,508	0	5,508	0	65.00
66.00	06600	PHYSICAL THERAPY	4,610	17,949	4,610	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,434	0	4,434	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,286	0	2,286	226	68.00
69.00	06900	ELECTROCARDIOLOGY	21,259	24,737	21,259	1,377	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,483	0	11,483	0	73.00
74.00	07400	RENAL DIALYSIS	2,326	0	2,326	365	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	188,576	14,731	188,576	19,904	90.00
91.00	09100	EMERGENCY	72,152	316,583	72,152	43,008	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,146,437	2,232,635	1,110,128	147,535	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	6,177	0	6,177	0	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	190.04
194.00	07950	COUNTYCARE	2,574	0	2,574	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	84,920,340	4,193,710	20,805,051	4,498,066	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	73.512138	1.878368	18.594550	30.488128	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	21,815,452	804,724	1,445,653	198,047	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	18.884763	0.360437	1.292055	1.342373	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0124

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

Worksheet B-1

Date/Time Prepared:
6/29/2021 4:24 pm

Cost Center Description			NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	SOCIAL SERVICE (TIME SPENT)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			13.00	14.00	16.00	17.00	21.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	5,036,244					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	150,706	124,788,645				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	116,540	0	1,196,717,319			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	56,160		17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	10,353	1,748	0	0	47,774	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	21,019	9,568	0	0	0	22.00
23.00	02300	ALLIED HEALTH	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	669,685	14,386	170,466,122	17,684	10,894	30.00
31.00	03100	INTENSIVE CARE UNIT	150,433	0	22,683,800	1,386	1,684	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	60,686	0	3,025,600	690	338	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	54,314	0	7,647,300	1,040	491	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	79,344	829	7,250,900	1,040	0	34.02
34.03	02400	NEURO INTENSIVE CARE	40,575	0	4,654,500	1,040	75	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	90,351	0	12,008,900	1,040	900	34.04
43.00	04300	NURSERY	48,134	3,883	4,503,048	0	278	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	283,589	9,891,175	149,665,768	0	7,990	50.00
51.00	05100	RECOVERY ROOM	57,358	0	12,648,850	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	55,206	0	1,740,822	0	637	52.00
53.00	05300	ANESTHESIOLOGY	38,795	369,863	54,333,976	0	3,119	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	254,043	1,436,537	156,933,677	0	2,006	54.00
60.00	06000	LABORATORY	225,526	5,459,304	134,806,135	0	1,029	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	17,353	3,013,233	12,276,730	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	82,183	1,007,596	17,282,522	0	876	65.00
66.00	06600	PHYSICAL THERAPY	62,009	93,955	6,796,114	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	27,020	6,062	2,833,426	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	10,964	146	1,301,277	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	40,379	2,261,353	35,271,252	0	1,278	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	19,174,100	14,467,239	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	14,577,817	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	407,801	81,015,653	183,429,254	0	102	73.00
74.00	07400	RENAL DIALYSIS	38,147	11,292	10,422,032	2,080	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,543,114	991,339	102,282,019	19,760	7,872	90.00
91.00	09100	EMERGENCY	400,617	26,623	53,408,239	10,400	8,205	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,036,244	124,788,645	1,196,717,319	56,160	47,774	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	0	0	0	0	0	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	18,535,913	34,889,093	15,759,549	434,244	53,042,640	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.680503	0.279585	0.013169	7.732265	1,110.282580	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,346,869	4,674,832	1,747,029	153,580	2,116,617	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.267435	0.037462	0.001460	2.734687	44.304789	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0124

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

Worksheet B-1

Date/Time Prepared:
6/29/2021 4:24 pm

Cost Center Description			INTERNS & RESIDENTS	ALLIED HEALTH (ASSIGNED TIME)	
			SERVICES-OTHER PRGM COSTS		
			APPRV (ASSIGNED TIME)		
			22.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	47,774		22.00
23.00	02300	ALLIED HEALTH		1,000	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	10,894	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,684	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	338	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	491	0	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	0	0	34.02
34.03	02400	NEURO INTENSIVE CARE	75	0	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	900	0	34.04
43.00	04300	NURSERY	278	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	7,990	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	637	0	52.00
53.00	05300	ANESTHESIOLOGY	3,119	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,006	0	54.00
60.00	06000	LABORATORY	1,029	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	876	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	1,278	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	102	1,000	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	7,872	0	90.00
91.00	09100	EMERGENCY	8,205	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	47,774	1,000	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.03	19003	SPECIAL FUNDS	0	0	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	190.04
194.00	07950	COUNTYCARE	0	0	194.00
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	13,658,370	432,421	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	285.895466	432.421000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	514,647	22,179	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	10.772533	22.179000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-0124	Period: From 12/01/2019 To 11/30/2020	Worksheet C Part I Date/Time Prepared: 6/29/2021 4:24 pm		
				Title XVIII	Hospital	PPS		
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance		Total Costs
			1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	136,234,723		136,234,723	116,882	136,351,605	30.00
31.00	03100	INTENSIVE CARE UNIT	18,536,273		18,536,273	0	18,536,273	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	7,547,561		7,547,561	0	7,547,561	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	8,811,151		8,811,151	0	8,811,151	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0		0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	17,053,408		17,053,408	0	17,053,408	34.02
34.03	02400	NEURO INTENSIVE CARE	4,747,924		4,747,924	0	4,747,924	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	13,648,195		13,648,195	0	13,648,195	34.04
43.00	04300	NURSERY	6,049,182		6,049,182	0	6,049,182	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	79,606,295		79,606,295	21,095	79,627,390	50.00
51.00	05100	RECOVERY ROOM	8,194,635		8,194,635	0	8,194,635	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,647,014		7,647,014	0	7,647,014	52.00
53.00	05300	ANESTHESIOLOGY	15,497,816		15,497,816	116,302	15,614,118	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	62,135,999		62,135,999	96,569	62,232,568	54.00
60.00	06000	LABORATORY	50,905,697		50,905,697	0	50,905,697	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	7,287,279		7,287,279	0	7,287,279	62.00
65.00	06500	RESPIRATORY THERAPY	10,508,084	0	10,508,084	0	10,508,084	65.00
66.00	06600	PHYSICAL THERAPY	6,897,661	0	6,897,661	0	6,897,661	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,794,104	0	2,794,104	0	2,794,104	67.00
68.00	06800	SPEECH PATHOLOGY	1,412,233	0	1,412,233	0	1,412,233	68.00
69.00	06900	ELECTROCARDIOLOGY	13,829,736		13,829,736	0	13,829,736	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	24,052,028		24,052,028	0	24,052,028	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,827,255		6,827,255	0	6,827,255	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	185,381,955		185,381,955	0	185,381,955	73.00
74.00	07400	RENAL DIALYSIS	6,666,006		6,666,006	0	6,666,006	74.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	267,808,234		267,808,234	1,444,741	269,252,975	90.00
91.00	09100	EMERGENCY	65,251,035		65,251,035	0	65,251,035	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	24,388,520		24,388,520		24,388,520	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	1,059,720,003	0	1,059,720,003	1,795,589	1,061,515,592	200.00
201.00		Less Observation Beds	24,388,520		24,388,520		24,388,520	201.00
202.00		Total (see instructions)	1,035,331,483	0	1,035,331,483	1,795,589	1,037,127,072	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet C
Part I
Date/Time Prepared:
6/29/2021 4:24 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	9.00	10.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	141,322,370		141,322,370			30.00	
31.00	03100	INTENSIVE CARE UNIT	22,683,800		22,683,800			31.00	
33.00	03300	BURN INTENSIVE CARE UNIT	3,025,600		3,025,600			33.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	7,647,300		7,647,300			34.00	
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0		0			34.01	
34.02	02180	TRAUMA INTENSIVE CARE UNIT	7,250,900		7,250,900			34.02	
34.03	02400	NEURO INTENSIVE CARE	4,654,500		4,654,500			34.03	
34.04	02060	NEONATAL INTENSIVE CARE UNIT	12,008,900		12,008,900			34.04	
43.00	04300	NURSERY	4,503,048		4,503,048			43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	84,067,368	65,598,400	149,665,768	0.531894	0.000000	50.00	
51.00	05100	RECOVERY ROOM	4,062,400	8,586,450	12,648,850	0.647856	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,695,719	45,103	1,740,822	4.392760	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	33,710,424	20,623,552	54,333,976	0.285233	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,194,573	114,739,104	156,933,677	0.395938	0.000000	54.00	
60.00	06000	LABORATORY	46,082,874	88,723,261	134,806,135	0.377622	0.000000	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	8,301,352	3,975,378	12,276,730	0.593585	0.000000	62.00	
65.00	06500	RESPIRATORY THERAPY	14,112,771	3,169,751	17,282,522	0.608018	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	3,677,370	3,118,744	6,796,114	1.014942	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	1,573,815	1,259,611	2,833,426	0.986122	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	514,608	786,669	1,301,277	1.085267	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	20,401,706	14,869,546	35,271,252	0.392097	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,772,486	4,694,753	14,467,239	1.662517	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,093,576	5,484,241	14,577,817	0.468332	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	70,671,205	112,758,049	183,429,254	1.010646	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	5,895,228	4,526,804	10,422,032	0.639607	0.000000	74.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,672,757	100,609,262	102,282,019	2.618332	0.000000	90.00	
91.00	09100	EMERGENCY	8,905,135	44,503,104	53,408,239	1.221741	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	11,452,454	17,691,298	29,143,752	0.836835	0.000000	92.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	580,954,239	615,763,080	1,196,717,319			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	580,954,239	615,763,080	1,196,717,319			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet C
Part I
Date/Time Prepared:
6/29/2021 4:24 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
33.00	03300	BURN INTENSIVE CARE UNIT			33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT			34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT			34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT			34.02
34.03	02400	NEURO INTENSIVE CARE			34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT			34.04
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.532035		50.00
51.00	05100	RECOVERY ROOM	0.647856		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4.392760		52.00
53.00	05300	ANESTHESIOLOGY	0.287373		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.396553		54.00
60.00	06000	LABORATORY	0.377622		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.593585		62.00
65.00	06500	RESPIRATORY THERAPY	0.608018		65.00
66.00	06600	PHYSICAL THERAPY	1.014942		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.986122		67.00
68.00	06800	SPEECH PATHOLOGY	1.085267		68.00
69.00	06900	ELECTROCARDIOLOGY	0.392097		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.662517		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.468332		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.010646		73.00
74.00	07400	RENAL DIALYSIS	0.639607		74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	2.632457		90.00
91.00	09100	EMERGENCY	1.221741		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.836835		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet C
Part I
Date/Time Prepared:
6/29/2021 4:24 pm

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	136,234,723		136,234,723	116,882	136,351,605	30.00
31.00	03100	INTENSIVE CARE UNIT	18,536,273		18,536,273	0	18,536,273	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	7,547,561		7,547,561	0	7,547,561	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	8,811,151		8,811,151	0	8,811,151	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0		0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	17,053,408		17,053,408	0	17,053,408	34.02
34.03	02400	NEURO INTENSIVE CARE	4,747,924		4,747,924	0	4,747,924	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	13,648,195		13,648,195	0	13,648,195	34.04
43.00	04300	NURSERY	6,049,182		6,049,182	0	6,049,182	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	79,606,295		79,606,295	21,095	79,627,390	50.00
51.00	05100	RECOVERY ROOM	8,194,635		8,194,635	0	8,194,635	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,647,014		7,647,014	0	7,647,014	52.00
53.00	05300	ANESTHESIOLOGY	15,497,816		15,497,816	116,302	15,614,118	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	62,135,999		62,135,999	96,569	62,232,568	54.00
60.00	06000	LABORATORY	50,905,697		50,905,697	0	50,905,697	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	7,287,279		7,287,279	0	7,287,279	62.00
65.00	06500	RESPIRATORY THERAPY	10,508,084	0	10,508,084	0	10,508,084	65.00
66.00	06600	PHYSICAL THERAPY	6,897,661	0	6,897,661	0	6,897,661	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,794,104	0	2,794,104	0	2,794,104	67.00
68.00	06800	SPEECH PATHOLOGY	1,412,233	0	1,412,233	0	1,412,233	68.00
69.00	06900	ELECTROCARDIOLOGY	13,829,736		13,829,736	0	13,829,736	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	24,052,028		24,052,028	0	24,052,028	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,827,255		6,827,255	0	6,827,255	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	185,381,955		185,381,955	0	185,381,955	73.00
74.00	07400	RENAL DIALYSIS	6,666,006		6,666,006	0	6,666,006	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	267,808,234		267,808,234	1,444,741	269,252,975	90.00
91.00	09100	EMERGENCY	65,251,035		65,251,035	0	65,251,035	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	24,388,520		24,388,520		24,388,520	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	1,059,720,003	0	1,059,720,003	1,795,589	1,061,515,592	200.00
201.00		Less Observation Beds	24,388,520		24,388,520		24,388,520	201.00
202.00		Total (see instructions)	1,035,331,483	0	1,035,331,483	1,795,589	1,037,127,072	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet C
Part I
Date/Time Prepared:
6/29/2021 4:24 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	141,322,370		141,322,370		30.00
31.00	03100	INTENSIVE CARE UNIT	22,683,800		22,683,800		31.00
33.00	03300	BURN INTENSIVE CARE UNIT	3,025,600		3,025,600		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	7,647,300		7,647,300		34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0		0		34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	7,250,900		7,250,900		34.02
34.03	02400	NEURO INTENSIVE CARE	4,654,500		4,654,500		34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	12,008,900		12,008,900		34.04
43.00	04300	NURSERY	4,503,048		4,503,048		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	84,067,368	65,598,400	149,665,768	0.531894	0.000000
51.00	05100	RECOVERY ROOM	4,062,400	8,586,450	12,648,850	0.647856	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,695,719	45,103	1,740,822	4.392760	0.000000
53.00	05300	ANESTHESIOLOGY	33,710,424	20,623,552	54,333,976	0.285233	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,194,573	114,739,104	156,933,677	0.395938	0.000000
60.00	06000	LABORATORY	46,082,874	88,723,261	134,806,135	0.377622	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	8,301,352	3,975,378	12,276,730	0.593585	0.000000
65.00	06500	RESPIRATORY THERAPY	14,112,771	3,169,751	17,282,522	0.608018	0.000000
66.00	06600	PHYSICAL THERAPY	3,677,370	3,118,744	6,796,114	1.014942	0.000000
67.00	06700	OCCUPATIONAL THERAPY	1,573,815	1,259,611	2,833,426	0.986122	0.000000
68.00	06800	SPEECH PATHOLOGY	514,608	786,669	1,301,277	1.085267	0.000000
69.00	06900	ELECTROCARDIOLOGY	20,401,706	14,869,546	35,271,252	0.392097	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,772,486	4,694,753	14,467,239	1.662517	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,093,576	5,484,241	14,577,817	0.468332	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	70,671,205	112,758,049	183,429,254	1.010646	0.000000
74.00	07400	RENAL DIALYSIS	5,895,228	4,526,804	10,422,032	0.639607	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,672,757	100,609,262	102,282,019	2.618332	0.000000
91.00	09100	EMERGENCY	8,905,135	44,503,104	53,408,239	1.221741	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	11,452,454	17,691,298	29,143,752	0.836835	0.000000
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	580,954,239	615,763,080	1,196,717,319		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	580,954,239	615,763,080	1,196,717,319		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet C
Part I
Date/Time Prepared:
6/29/2021 4:24 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
33.00	03300	BURN INTENSIVE CARE UNIT				33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT				34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT				34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT				34.02
34.03	02400	NEURO INTENSIVE CARE				34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT				34.04
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000	LABORATORY	0.000000			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000			62.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet D
Part I
Date/Time Prepared:
6/29/2021 4:24 pm

			Title XVIII		Hospital	PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	20,241,880	0	20,241,880	71,635	282.57	30.00	
31.00	INTENSIVE CARE UNIT	1,835,467		1,835,467	8,667	211.78	31.00	
33.00	BURN INTENSIVE CARE UNIT	542,757		542,757	1,352	401.45	33.00	
34.00	SURGICAL INTENSIVE CARE UNIT	731,731		731,731	2,977	245.79	34.00	
34.01	PEDIATRIC INTENSIVE CARE UNIT	0		0	0	0.00	34.01	
34.02	TRAUMA INTENSIVE CARE UNIT	1,945,621		1,945,621	2,519	772.38	34.02	
34.03	NEURO INTENSIVE CARE	373,524		373,524	1,986	188.08	34.03	
34.04	NEONATAL INTENSIVE CARE UNIT	1,048,659		1,048,659	5,568	188.34	34.04	
43.00	NURSERY	574,270		574,270	1,526	376.32	43.00	
200.00	Total (lines 30 through 199)	27,293,909		27,293,909	96,230		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	6,611	1,868,070					30.00
31.00	INTENSIVE CARE UNIT	897	189,967					31.00
33.00	BURN INTENSIVE CARE UNIT	144	57,809					33.00
34.00	SURGICAL INTENSIVE CARE UNIT	313	76,932					34.00
34.01	PEDIATRIC INTENSIVE CARE UNIT	0	0					34.01
34.02	TRAUMA INTENSIVE CARE UNIT	219	169,151					34.02
34.03	NEURO INTENSIVE CARE	258	48,525					34.03
34.04	NEONATAL INTENSIVE CARE UNIT	0	0					34.04
43.00	NURSERY	0	0					43.00
200.00	Total (lines 30 through 199)	8,442	2,410,454					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet D
Part II
Date/Time Prepared:
6/29/2021 4:24 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	10,206,479	149,665,768	0.068195	6,843,800	466,713	50.00	
51.00	05100	RECOVERY ROOM	865,349	12,648,850	0.068413	311,750	21,328	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	833,397	1,740,822	0.478738	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	1,604,918	54,333,976	0.029538	2,493,528	73,654	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,685,392	156,933,677	0.042600	3,744,581	159,519	54.00	
60.00	06000	LABORATORY	5,565,590	134,806,135	0.041286	5,139,219	212,178	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	468,911	12,276,730	0.038195	425,012	16,233	62.00	
65.00	06500	RESPIRATORY THERAPY	1,443,032	17,282,522	0.083497	1,896,120	158,320	65.00	
66.00	06600	PHYSICAL THERAPY	461,290	6,796,114	0.067876	452,598	30,721	66.00	
67.00	06700	OCCUPATIONAL THERAPY	280,717	2,833,426	0.099073	177,471	17,583	67.00	
68.00	06800	SPEECH PATHOLOGY	151,092	1,301,277	0.116111	94,707	10,997	68.00	
69.00	06900	ELECTROCARDIOLOGY	2,435,241	35,271,252	0.069043	1,999,301	138,038	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,386,683	14,467,239	0.095850	1,041,826	99,859	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	253,424	14,577,817	0.017384	640,525	11,135	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	11,140,595	183,429,254	0.060735	7,758,414	471,207	73.00	
74.00	07400	RENAL DIALYSIS	379,967	10,422,032	0.036458	1,012,866	36,927	74.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	19,563,918	102,282,019	0.191274	798,626	152,756	90.00	
91.00	09100	EMERGENCY	5,608,597	53,408,239	0.105014	901,205	94,639	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,620,573	29,143,752	0.124232	1,257,953	156,278	92.00	
200.00	Total (lines 50 through 199)		72,955,165	993,620,901		36,989,502	2,328,085	200.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0124		Period: From 12/01/2019 To 11/30/2020		Worksheet D Part III Date/Time Prepared: 6/29/2021 4:24 pm		
					Title XVIII		Hospital		PPS		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost				
			1A	1.00	2A	2.00	3.00				
	INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	0	31.00	
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	0	0	33.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	0	0	34.00	
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	0	0	0	34.01	
34.02	02180	TRAUMA INTENSIVE CARE UNIT	0	0	0	0	0	0	0	34.02	
34.03	02400	NEURO INTENSIVE CARE	0	0	0	0	0	0	0	34.03	
34.04	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	0	0	34.04	
43.00	04300	NURSERY	0	0	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days				
			4.00	5.00	6.00	7.00	8.00				
	INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	71,635	0.00	6,611		30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	8,667	0.00	897		31.00		
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	1,352	0.00	144		33.00		
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	2,977	0.00	313		34.00		
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0.00	0		34.01		
34.02	02180	TRAUMA INTENSIVE CARE UNIT	0	0	2,519	0.00	219		34.02		
34.03	02400	NEURO INTENSIVE CARE	0	0	1,986	0.00	258		34.03		
34.04	02060	NEONATAL INTENSIVE CARE UNIT	0	0	5,568	0.00	0		34.04		
43.00	04300	NURSERY	0	0	1,526	0.00	0		43.00		
200.00		Total (lines 30 through 199)	0	0	96,230	0.00	8,442		200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)								
			9.00								
	INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0								30.00
31.00	03100	INTENSIVE CARE UNIT	0								
33.00	03300	BURN INTENSIVE CARE UNIT	0								
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0								
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0								
34.02	02180	TRAUMA INTENSIVE CARE UNIT	0								
34.03	02400	NEURO INTENSIVE CARE	0								
34.04	02060	NEONATAL INTENSIVE CARE UNIT	0								
43.00	04300	NURSERY	0								
200.00		Total (lines 30 through 199)	0								

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet D
Part IV
Date/Time Prepared:
6/29/2021 4:24 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	432,421	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	432,421	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet D
Part IV
Date/Time Prepared:
6/29/2021 4:24 pm

				Title XVIII		Hospital	PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	149,665,768	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	12,648,850	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,740,822	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	54,333,976	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	156,933,677	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	134,806,135	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	12,276,730	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	17,282,522	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,796,114	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,833,426	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,301,277	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	35,271,252	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	14,467,239	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,577,817	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	432,421	432,421	183,429,254	0.002357	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	10,422,032	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	102,282,019	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	53,408,239	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	29,143,752	0.000000	92.00
200.00	Total (lines 50 through 199)		0	432,421	432,421	993,620,901		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet D
Part IV
Date/Time Prepared:
6/29/2021 4:24 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	6,843,800	0	1,293,843	0
51.00	05100	RECOVERY ROOM	0.000000	311,750	0	531,000	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0.000000	2,493,528	0	985,096	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	3,744,581	0	9,319,243	0
60.00	06000	LABORATORY	0.000000	5,139,219	0	3,868,011	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	425,012	0	68,656	0
65.00	06500	RESPIRATORY THERAPY	0.000000	1,896,120	0	179,907	0
66.00	06600	PHYSICAL THERAPY	0.000000	452,598	0	6,862	0
67.00	06700	OCCUPATIONAL THERAPY	0.000000	177,471	0	1,238	0
68.00	06800	SPEECH PATHOLOGY	0.000000	94,707	0	84,092	0
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,999,301	0	1,288,860	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,041,826	0	270,579	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	640,525	0	522,573	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.002357	7,758,414	18,287	15,952,786	37,601
74.00	07400	RENAL DIALYSIS	0.000000	1,012,866	0	52,183	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	798,626	0	11,832,148	0
91.00	09100	EMERGENCY	0.000000	901,205	0	1,657,183	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,257,953	0	1,578,612	0
200.00		Total (lines 50 through 199)		36,989,502	18,287	49,492,872	37,601

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet D
Part V
Date/Time Prepared:
6/29/2021 4:24 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	0.531894	1,293,843	0	0	688,187	50.00	
51.00	05100	RECOVERY ROOM	0.647856	531,000	0	0	344,012	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	4.392760	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.285233	985,096	0	0	280,982	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.395938	9,319,243	0	0	3,689,842	54.00	
60.00	06000	LABORATORY	0.377622	3,868,011	0	0	1,460,646	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.593585	68,656	0	0	40,753	62.00	
65.00	06500	RESPIRATORY THERAPY	0.608018	179,907	0	0	109,387	65.00	
66.00	06600	PHYSICAL THERAPY	1.014942	6,862	0	0	6,965	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.986122	1,238	0	0	1,221	67.00	
68.00	06800	SPEECH PATHOLOGY	1.085267	84,092	0	0	91,262	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.392097	1,288,860	0	0	505,358	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.662517	270,579	0	0	449,842	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.468332	522,573	0	0	244,738	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	1.010646	15,952,786	27,919	334,799	16,122,619	73.00	
74.00	07400	RENAL DIALYSIS	0.639607	52,183	0	0	33,377	74.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2.618332	11,832,148	0	0	30,980,492	90.00	
91.00	09100	EMERGENCY	1.221741	1,657,183	0	0	2,024,648	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.836835	1,578,612	0	0	1,321,038	92.00	
200.00		Subtotal (see instructions)		49,492,872	27,919	334,799	58,395,369	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		49,492,872	27,919	334,799	58,395,369	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet D
Part V
Date/Time Prepared:
6/29/2021 4:24 pm

			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,216	338,363		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	28,216	338,363		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	28,216	338,363		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet D
Part V
Date/Time Prepared:
6/29/2021 4:24 pm

			Title XIX		Hospital		Cost	
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	0.531894	0	1,756,442	0	0	50.00
51.00	05100	RECOVERY ROOM	0.647856	0	1,143,792	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4.392760	0	6,008	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.285233	0	2,959,332	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.395938	0	6,033,497	0	0	54.00
60.00	06000	LABORATORY	0.377622	0	4,410,478	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.593585	0	57,070	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.608018	0	2,533,780	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1.014942	0	57,376	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.986122	0	38,277	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.085267	0	25,915	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.392097	0	770,805	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.662517	0	766,384	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.468332	0	895,262	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.010646	0	3,438,603	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.639607	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2.618332	0	8,053,376	0	0	90.00
91.00	09100	EMERGENCY	1.221741	0	5,408,966	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.836835	0	1,682,279	0	0	92.00
200.00		Subtotal (see instructions)		0	40,037,642	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	40,037,642	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet D
Part V
Date/Time Prepared:
6/29/2021 4:24 pm

			Title XIX		Hospital	Cost
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	934,241	0		50.00
51.00	05100	RECOVERY ROOM	741,013	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	26,392	0		52.00
53.00	05300	ANESTHESIOLOGY	844,099	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,388,891	0		54.00
60.00	06000	LABORATORY	1,665,494	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	33,876	0		62.00
65.00	06500	RESPIRATORY THERAPY	1,540,584	0		65.00
66.00	06600	PHYSICAL THERAPY	58,233	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	37,746	0		67.00
68.00	06800	SPEECH PATHOLOGY	28,125	0		68.00
69.00	06900	ELECTROCARDIOLOGY	302,230	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,274,126	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	419,280	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,475,210	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	21,086,412	0		90.00
91.00	09100	EMERGENCY	6,608,356	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,407,790	0		92.00
200.00		Subtotal (see instructions)	42,872,098	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	42,872,098	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0124	Period: From 12/01/2019 To 11/30/2020	Worksheet D-1 Date/Time Prepared: 6/29/2021 4:24 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)	71,635	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	71,635	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)	58,822	4.00	
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00	
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00	
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	6,611	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)	136,351,605	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)	136,351,605	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)	136,351,605	37.00	
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,903.42	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)	12,583,510	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)	12,583,510	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0124

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

Worksheet D-1

Date/Time Prepared:
6/29/2021 4:24 pm

			Title XVIII		Hospital	PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		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	18,536,273	8,667	2,138.72	897	1,918,432	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT	7,547,561	1,352	5,582.52	144	803,883	45.00
46.00	SURGICAL INTENSIVE CARE UNIT	8,811,151	2,977	2,959.74	313	926,399	46.00
46.01	PEDIATRIC INTENSIVE CARE UNIT	0	0	0.00	0	0	46.01
46.02	TRAUMA INTENSIVE CARE UNIT	17,053,408	2,519	6,769.91	219	1,482,610	46.02
46.03	NEURO INTENSIVE CARE	4,747,924	1,986	2,390.70	258	616,801	46.03
46.04	NEONATAL INTENSIVE CARE UNIT	13,648,195	5,568	2,451.18	0	0	46.04
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					25,688,481	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					44,020,116	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					2,410,454	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,346,372	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					4,756,826	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					39,263,290	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)					12,813	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,903.42	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					24,388,520	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0124

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

Worksheet D-1

Date/Time Prepared:
6/29/2021 4:24 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	20,241,880	136,351,605	0.148454	24,388,520	3,620,573	90.00
91.00 Nursing School cost	0	136,351,605	0.000000	24,388,520	0	91.00
92.00 Allied health cost	0	136,351,605	0.000000	24,388,520	0	92.00
93.00 All other Medical Education	0	136,351,605	0.000000	24,388,520	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0124	Period: From 12/01/2019 To 11/30/2020	Worksheet D-1 Date/Time Prepared: 6/29/2021 4:24 pm
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			71,635 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			71,635 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)			58,822 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			12,714 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			1,526 15.00
16.00	Nursery days (title V or XIX only)			330 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)			136,234,723 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)			136,234,723 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)			136,234,723 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,901.79 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			24,179,358 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)			24,179,358 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0124

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

Worksheet D-1

Date/Time Prepared:
6/29/2021 4:24 pm

			Title XIX		Hospital	Cost		
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	6,049,182	1,526	3,964.08	330	1,308,146	42.00	
	Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	18,536,273	8,667	2,138.72	1,874	4,007,961	43.00	
44.00	CORONARY CARE UNIT						44.00	
45.00	BURN INTENSIVE CARE UNIT	7,547,561	1,352	5,582.52	292	1,630,096	45.00	
46.00	SURGICAL INTENSIVE CARE UNIT	8,811,151	2,977	2,959.74	644	1,906,073	46.00	
46.01	PEDIATRIC INTENSIVE CARE UNIT	0	0	0.00	0	0	46.01	
46.02	TRAUMA INTENSIVE CARE UNIT	17,053,408	2,519	6,769.91	545	3,689,601	46.02	
46.03	NEURO INTENSIVE CARE	4,747,924	1,986	2,390.70	429	1,025,610	46.03	
46.04	NEONATAL INTENSIVE CARE UNIT	13,648,195	5,568	2,451.18	1,204	2,951,221	46.04	
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00	
	Cost Center Description							
						1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						37,652,236	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						78,350,302	49.00
	PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
56.00	Target amount (line 54 x line 55)						0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00	Bonus payment (see instructions)						0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00	Relief payment (see instructions)						0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)						12,813	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,901.79	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						24,367,635	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0124

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

Worksheet D-1

Date/Time Prepared:
6/29/2021 4:24 pm

		Title XIX		Hospital	Cost	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	20,241,880	136,234,723	0.148581	24,367,635	3,620,568	90.00
91.00 Nursing School cost	0	136,234,723	0.000000	24,367,635	0	91.00
92.00 Allied health cost	0	136,234,723	0.000000	24,367,635	0	92.00
93.00 All other Medical Education	0	136,234,723	0.000000	24,367,635	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0124	Period: From 12/01/2019 To 11/30/2020	Worksheet D-3 Date/Time Prepared: 6/29/2021 4:24 pm	
Cost Center Description		Title XVIII	Hospital	PPS	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	14,311,832		30.00
31.00	03100	INTENSIVE CARE UNIT	2,601,300		31.00
33.00	03300	BURN INTENSIVE CARE UNIT	446,400		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	907,700		34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0		34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	678,900		34.02
34.03	02400	NEURO INTENSIVE CARE	748,200		34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	0		34.04
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	6,843,800	3,641,141	50.00
51.00	05100	RECOVERY ROOM	311,750	201,969	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	2,493,528	716,573	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,744,581	1,484,925	54.00
60.00	06000	LABORATORY	5,139,219	1,940,682	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	425,012	252,281	62.00
65.00	06500	RESPIRATORY THERAPY	1,896,120	1,152,875	65.00
66.00	06600	PHYSICAL THERAPY	452,598	459,361	66.00
67.00	06700	OCCUPATIONAL THERAPY	177,471	175,008	67.00
68.00	06800	SPEECH PATHOLOGY	94,707	102,782	68.00
69.00	06900	ELECTROCARDIOLOGY	1,999,301	783,920	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,041,826	1,732,053	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	640,525	299,978	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,758,414	7,841,010	73.00
74.00	07400	RENAL DIALYSIS	1,012,866	647,836	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	798,626	2,102,349	90.00
91.00	09100	EMERGENCY	901,205	1,101,039	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,257,953	1,052,699	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)	36,989,502	25,688,481	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)	36,989,502		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0124	Period: From 12/01/2019 To 11/30/2020	Worksheet D-3 Date/Time Prepared: 6/29/2021 4:24 pm	
Cost Center Description		Title XIX	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	25,694,757		30.00
31.00	03100	INTENSIVE CARE UNIT	4,124,292		31.00
33.00	03300	BURN INTENSIVE CARE UNIT	550,104		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,390,406		34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0		34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	1,318,334		34.02
34.03	02400	NEURO INTENSIVE CARE	846,265		34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	2,183,418		34.04
43.00	04300	NURSERY	818,729		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	12,273,028	6,527,950	50.00
51.00	05100	RECOVERY ROOM	427,326	276,846	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	178,374	783,554	52.00
53.00	05300	ANESTHESIOLOGY	4,765,016	1,359,140	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,816,986	1,115,352	54.00
60.00	06000	LABORATORY	8,775,232	3,313,721	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	687,173	407,896	62.00
65.00	06500	RESPIRATORY THERAPY	5,160,924	3,137,935	65.00
66.00	06600	PHYSICAL THERAPY	653,659	663,426	66.00
67.00	06700	OCCUPATIONAL THERAPY	287,485	283,495	67.00
68.00	06800	SPEECH PATHOLOGY	93,825	101,825	68.00
69.00	06900	ELECTROCARDIOLOGY	1,642,599	644,058	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,566,729	2,604,714	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,457,886	682,775	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,161,965	11,280,795	73.00
74.00	07400	RENAL DIALYSIS	940,614	601,623	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	874,131	2,288,765	90.00
91.00	09100	EMERGENCY	72,142	88,139	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,780,789	1,490,227	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)	55,615,883	37,652,236	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)	55,615,883		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0124	Period: From 12/01/2019 To 11/30/2020	Worksheet E Part A Date/Time Prepared: 6/29/2021 4:24 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)		12,579,401	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		2,424,681	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)		2,077,900	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		118,167	2.04
3.00	Managed Care Simulated Payments		7,896,789	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		424.99	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		522.08	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		36.60	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		-85.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		400.48	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		462.17	10.00
11.00	FTE count for residents in dental and podiatric programs.		13.01	11.00
12.00	Current year allowable FTE (see instructions)		413.49	12.00
13.00	Total allowable FTE count for the prior year.		415.84	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.		415.10	14.00
15.00	Sum of lines 12 through 14 divided by 3.		414.81	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		414.81	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.976046	19.00
20.00	Prior year resident to bed ratio (see instructions)		1.040328	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.976046	21.00
22.00	IME payment adjustment (see instructions)		6,434,020	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		3,386,285	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C) .		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		61.69	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)		6,434,020	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		3,386,285	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		17.09	30.00
31.00	Percentage of Medicaid patient days (see instructions)		51.20	31.00
32.00	Sum of lines 30 and 31		68.29	32.00
33.00	Allowable disproportionate share percentage (see instructions)		45.55	33.00
34.00	Disproportionate share adjustment (see instructions)		1,708,590	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0124	Period: From 12/01/2019 To 11/30/2020	Worksheet E Part A Date/Time Prepared: 6/29/2021 4:24 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)	61,124,317	76,429,439	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	50,936,910	12,773,117	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	63,710,027		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	40.00
			Before 1/1	On/After 1/1
			1.00	1.01
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0 41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 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 an 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)	89,052,786		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)		92,439,071	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,496,903	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		2,517,893	52.00
53.00	Nursing and Allied Health Managed Care payment		3,551	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 intructions)		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)		18,287	58.00
59.00	Total (sum of amounts on lines 49 through 58)		97,475,705	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		97,475,705	61.00
62.00	Deductibles billed to program beneficiaries		1,328,580	62.00
63.00	Coinsurance billed to program beneficiaries		110,275	63.00
64.00	Allowable bad debts (see instructions)		1,030,326	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		669,712	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		357,356	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		96,706,562	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)		70,807	70.93
70.94	HRR adjustment amount (see instructions)		-54,637	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0124	Period: From 12/01/2019 To 11/30/2020	Worksheet E Part A Date/Time Prepared: 6/29/2021 4:24 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)		201,164	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		96,521,568	71.00
71.01	Sequestration adjustment (see instructions)		801,129	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		74,535,104	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		21,185,335	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		132,235	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
			Prior to 10/1	On/After 10/1
			1.00	2.00
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
6/29/2021 4:24 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	12,579,401	0	12,579,401		12,579,401
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,424,681	0		2,424,681	2,424,681
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	2,077,900	0	2,077,900		2,077,900
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	118,167	0		118,167	118,167
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	7,896,789	0	6,414,337	1,482,452	7,896,789
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.976046	0.976046	0.976046	0.976046	
6.00	IME payment adjustment (see instructions)	22.00	6,434,020	0	5,394,273	1,039,747	6,434,020
6.01	IME payment adjustment for managed care (see instructions)	22.01	3,386,285	0	2,750,583	635,702	3,386,285
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	6,434,020	0	5,394,273	1,039,747	6,434,020
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	3,386,285	0	2,750,583	635,702	3,386,285
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.4555	0.4555	0.4555	0.4555	
11.00	Disproportionate share adjustment (see instructions)	34.00	1,708,590	0	1,432,479	276,111	1,708,590
11.01	Uncompensated care payments	36.00	63,710,027	0	50,936,910	12,773,117	63,710,027
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	89,052,786	0	72,420,963	16,631,823	89,052,786
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	92,439,071	0	75,171,546	17,267,525	92,439,071
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,496,903	0	-356,696	2,853,599	2,496,903

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
6/29/2021 4:24 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	74,814,850	20,121,124	94,935,974
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	1,173,019	0	-185,011	1,358,030	1,173,019
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	531,744	0	-46,747	578,491	531,744
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.5270	0.5270	0.5270	0.5270	
23.00	Indirect medical education adjustment (see instructions)	6.00	618,181	0	-97,501	715,682	618,181
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1483	0.1483	0.1483	0.1483	
25.00	Disproportionate share adjustment (see instructions)	11.00	173,959	0	-27,437	201,396	173,959
26.00	Total prospective capital payments (see instructions)	12.00	2,496,903	0	-356,696	2,853,599	2,496,903
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.000000	0.000000	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5				Provider CCN: 14-0124	Period: From 12/01/2019 To 11/30/2020	Worksheet E Part A Exhibit 5 Date/Time Prepared: 6/29/2021 4:24 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				
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	12,579,401	12,579,401		12,579,401
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,424,681		2,424,681	2,424,681
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00				
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	2,077,900	2,077,900		2,077,900
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	118,167		118,167	118,167
3.00	Operating outlier reconciliation	2.01	0	0	0	0
4.00	Managed care simulated payments	3.00	7,896,789	6,414,337	1,482,452	7,896,789
Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.976046	0.976046	0.976046	
6.00	IME payment adjustment (see instructions)	22.00	6,434,020	5,394,273	1,039,747	6,434,020
6.01	IME payment adjustment for managed care (see instructions)	22.01	3,386,285	2,750,583	635,702	3,386,285
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	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	6,434,020	5,394,273	1,039,747	6,434,020
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	3,386,285	2,750,583	635,702	3,386,285
Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.4555	0.4555	0.4555	
11.00	Disproportionate share adjustment (see instructions)	34.00	1,708,590	1,432,479	276,111	1,708,590
11.01	Uncompensated care payments	36.00	63,710,027	50,936,910	12,773,117	63,710,027
Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0
13.00	Subtotal (see instructions)	47.00	89,052,786	72,420,963	16,631,823	89,052,786
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	92,439,071	75,171,546	17,267,525	92,439,071
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,496,903	-356,696	2,853,599	2,496,903
17.00	Special add-on payments for new technologies	54.00	0	0	0	0
17.01	Net organ acquisition cost					
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0
19.00	SUBTOTAL			74,814,850	20,121,124	94,935,974

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
6/29/2021 4:24 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,173,019	-185,011	1,358,030	1,173,019	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	531,744	-46,747	578,491	531,744	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.5270	0.5270	0.5270		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	618,181	-97,501	715,682	618,181	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1483	0.1483	0.1483		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	173,959	-27,437	201,396	173,959	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2,496,903	-356,696	2,853,599	2,496,903	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	70,807	69,913	894	70,807	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	-54,637	-49,060	-5,577	-54,637	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	201,164	201,164	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0124	Period: From 12/01/2019 To 11/30/2020	Worksheet E Part B Date/Time Prepared: 6/29/2021 4:24 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		366,579	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		58,357,768	2.00
3.00	OPPS payments		16,023,766	3.00
4.00	Outlier payment (see instructions)		1,706,810	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		37,601	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		366,579	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		362,718	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)		362,718	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)		362,718	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		3,861	20.00
21.00	Lesser of cost or charges (see instructions)		362,718	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)		17,768,177	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)		3,573,488	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)		14,557,407	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		3,361,105	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)		17,918,512	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		17,918,512	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)		3,024,586	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		1,965,981	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		363,603	36.00
37.00	Subtotal (see instructions)		19,884,493	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)		19,884,493	40.00
40.01	Sequestration adjustment (see instructions)		165,041	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		19,543,960	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		175,492	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet E-1
Part I
Date/Time Prepared:
6/29/2021 4:24 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		74,563,042		19,802,796	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	08/24/2020	27,938	08/24/2020	258,836	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)		-27,938		-258,836	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)		74,535,104		19,543,960	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		21,185,335		175,492	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		95,720,439		19,719,452	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet E-1
Part II
Date/Time Prepared:
6/29/2021 4:24 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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0124	Period: From 12/01/2019 To 11/30/2020	Worksheet E-3 Part VII Date/Time Prepared: 6/29/2021 4:24 pm
		Title XIX	Hospital	Cost
			Inpatient	Outpatient
			1.00	2.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	78,350,302		1.00
2.00	Medical and other services		42,872,098	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	78,350,302	42,872,098	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	78,350,302	42,872,098	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	36,926,306		8.00
9.00	Ancillary service charges	55,615,883	40,037,642	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	92,542,189	40,037,642	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	92,542,189	40,037,642	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	14,191,887	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	2,834,456	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	78,350,302	40,037,642	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	78,350,302	40,037,642	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	2,834,456	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	78,350,302	40,037,642	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	78,350,302	40,037,642	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	78,350,302	40,037,642	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	78,350,302	40,037,642	40.00
41.00	Interim payments	78,350,302	40,037,642	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0124		Period: From 12/01/2019 To 11/30/2020	Worksheet E-4 Date/Time Prepared: 6/29/2021 4:24 pm
		Title XVIII		Hospital	PPS
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			526.48	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			65.83	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			-60.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			400.65	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			465.91	6.00
7.00	Enter the lesser of line 5 or line 6			400.65	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	191.29	229.56	420.85	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.	164.50	197.41	361.91	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		12.55		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	164.50	209.96		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	166.78	209.88		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	172.18	202.91		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	167.82	207.58		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	167.82	207.58		17.00
18.00	Per resident amount	101,947.73	101,084.57		18.00
19.00	Approved amount for resident costs	17,108,868	20,983,135	38,092,003	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			65.26	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			38,092,003	25.00
		Inpatient Part A	Managed Care Prior to 1/1	Managed Care On or after 1/1	Total
		1.00	2.00	2.01	3.00
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	8,442	418	4,252	26.00
27.00	Total Inpatient Days (see instructions)	82,839	82,839	82,839	27.00
28.00	Ratio of inpatient days to total inpatient days	0.101909	0.005046	0.051328	28.00
29.00	Program direct GME amount	3,881,918	192,212	1,955,186	29.00
29.01	Percent reduction for MA DGME		7.00	7.00	29.01
30.00	Reduction for direct GME payments for Medicare Advantage		13,455	136,863	30.00
31.00	Net Program direct GME amount			5,878,998	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0124	Period: From 12/01/2019 To 11/30/2020	Worksheet E-4 Date/Time Prepared: 6/29/2021 4:24 pm
		Title XVIII	Hospital	PPS
				1.00
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)			
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		10,422,032	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		881	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		44,020,116	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)		44,020,116	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		58,761,948	42.00
43.00	Primary payer payments (see instructions)		0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		58,761,948	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		102,782,064	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.428286	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.571714	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		5,878,998	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		2,517,893	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		3,361,105	50.00

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

Provider CCN: 14-0124

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

Worksheet G

Date/Time Prepared:
6/29/2021 4:24 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	260,260,152	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	48,095,881	0	0	0	4.00
5.00 Other receivable	30,575,998	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00 Inventory	8,143,015	0	0	0	7.00
8.00 Prepaid expenses	0	0	0	0	8.00
9.00 Other current assets	947,485,660	0	0	0	9.00
10.00 Due from other funds	0	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	1,294,560,706	0	0	0	11.00
FIXED ASSETS					
12.00 Land	990,911	0	0	0	12.00
13.00 Land improvements	2,631,393	0	0	0	13.00
14.00 Accumulated depreciation	-2,164,241	0	0	0	14.00
15.00 Buildings	842,463,188	0	0	0	15.00
16.00 Accumulated depreciation	-362,337,863	0	0	0	16.00
17.00 Leasehold improvements	0	0	0	0	17.00
18.00 Accumulated depreciation	0	0	0	0	18.00
19.00 Fixed equipment	13,838,437	0	0	0	19.00
20.00 Accumulated depreciation	-11,868,830	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	177,511,200	0	0	0	23.00
24.00 Accumulated depreciation	-152,538,898	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)	508,525,297	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	0	0	0	0	31.00
32.00 Deposits on leases	0	0	0	0	32.00
33.00 Due from owners/officers	0	0	0	0	33.00
34.00 Other assets	0	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	1,803,086,003	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	65,198,365	0	0	0	37.00
38.00 Salaries, wages, and fees payable	55,543,540	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	1,701,163	0	0	0	43.00
44.00 Other current liabilities	31,406,886	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	153,849,954	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)	153,849,954	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	1,649,236,049	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	1,649,236,049	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	1,803,086,003	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0124

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

Worksheet G-1

Date/Time Prepared:
6/29/2021 4:24 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		1,474,807,079		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		76,288,347				2.00
3.00	Total (sum of line 1 and line 2)		1,551,095,426		0		3.00
4.00	OTHER	98,140,622		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	Rounding	1		0		0	9.00
10.00	Total additions (sum of line 4-9)		98,140,623		0		10.00
11.00	Subtotal (line 3 plus line 10)		1,649,236,049		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)		1,649,236,049		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	OTHER		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00	Rounding		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: 14-0124

Period:
From 12/01/2019
To 11/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
6/29/2021 4:24 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	159,680,872		159,680,872	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)	159,680,872		159,680,872	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	25,129,848		25,129,848	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT	4,098,032		4,098,032	13.00
14.00	SURGICAL INTENSIVE CARE UNIT	8,601,480		8,601,480	14.00
14.01	PEDIATRIC INTENSIVE CARE UNIT	0		0	14.01
14.02	TRAUMA INTENSIVE CARE UNIT	8,249,824		8,249,824	14.02
14.03	NEURO INTENSIVE CARE	5,651,332		5,651,332	14.03
14.04	NEONATAL INTENSIVE CARE UNIT	15,396,604		15,396,604	14.04
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	67,127,120		67,127,120	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	226,807,992		226,807,992	17.00
18.00	Ancillary services	384,889,543	482,506,858	867,396,401	18.00
19.00	Outpatient services	11,849,994	233,408,406	245,258,400	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	Other Patient Service Revenue	100,240,833	135,756,271	235,997,104	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	723,788,362	851,671,535	1,575,459,897	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		980,115,692		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)		980,115,692		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0124

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

Worksheet G-3

Date/Time Prepared:
6/29/2021 4:24 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,575,459,897	1.00
2.00	Less contractual allowances and discounts on patients' accounts	759,996,448	2.00
3.00	Net patient revenues (line 1 minus line 2)	815,463,449	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	980,115,692	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-164,652,243	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	150,824	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	0	24.00
24.01	Misc Income	8,853,941	24.01
24.02	Revenue from county	2,327,339	24.02
24.03	EHR Incentive Revenue	1,537,169	24.03
24.04	Graduate Medical Education	75,578,605	24.04
24.50	COVID-19 PHE Funding	152,492,712	24.50
25.00	Total other income (sum of lines 6-24)	240,940,590	25.00
26.00	Total (line 5 plus line 25)	76,288,347	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)	76,288,347	29.00

ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

Provider CCN: 14-0124

Period:

Worksheet I-1

Component CCN: 14-2313

From 12/01/2019
To 11/30/2020Date/Time Prepared:
6/29/2021 4:24 pm

		Renal Dialysis			
		Total Costs	Basis	Statistics	FTEs per 2080 Hours
		1.00	2.00	3.00	4.00
1.00	REGISTERED NURSES	828,427	HOURS OF SERVICE	17,248.00	8.29
2.00	LICENSED PRACTICAL NURSES	0	HOURS OF SERVICE	0.00	0.00
3.00	NURSES AIDES	56,000	HOURS OF SERVICE	2,080.00	1.00
4.00	TECHNICIANS	244,087	HOURS OF SERVICE	9,364.00	4.50
5.00	SOCIAL WORKERS	0	HOURS OF SERVICE	0.00	0.00
6.00	DIETICIANS	0	HOURS OF SERVICE	0.00	0.00
7.00	PHYSICIANS	1,164,723	ACCUMULATED COST		7.00
8.00	NON-PATIENT CARE SALARY	221,469	ACCUMULATED COST		8.00
9.00	SUBTOTAL (SUM OF LINES 1-8)	2,514,706			9.00
10.00	EMPLOYEE BENEFITS	0	SALARY		10.00
11.00	CAPITAL RELATED COSTS-BLDGS. & FIXTURES	0	SQUARE FEET		11.00
12.00	CAPITAL RELATED COSTS-MOV. EQUIP.	0	PERCENTAGE OF TIME		12.00
13.00	MACHINE COSTS & REPAIRS	0	PERCENTAGE OF TIME		13.00
14.00	SUPPLIES	399	REQUISITIONS		14.00
15.00	DRUGS	0	REQUISITIONS		15.00
16.00	OTHER	109,858	ACCUMULATED COST		16.00
17.00	SUBTOTAL (SUM OF LINES 9-16)*	2,624,963			17.00
18.00	CAPITAL RELATED COSTS-BLDGS. & FIXTURES	49,320	SQUARE FEET		18.00
19.00	CAPITAL RELATED COSTS-MOV. EQUIP.	20,009	PERCENTAGE OF TIME		19.00
20.00	EMPLOYEE BENEFITS DEPARTMENT	1,921,503	SALARY		20.00
21.00	ADMINISTRATIVE & GENERAL	1,435,212	ACCUMULATED COST		21.00
22.00	MAINT./REPAIRS-OPER-HOUSEKEEPING	214,240	SQUARE FEET		22.00
23.00	MEDICAL EDUCATION PROGRAM COSTS	0			23.00
24.00	CENTRAL SERVICE & SUPPLIES	3,157	REQUISITIONS		24.00
25.00	PHARMACY	0	REQUISITIONS		25.00
26.00	OTHER ALLOCATED COSTS	397,602	ACCUMULATED COST		26.00
27.00	SUBTOTAL (SUM OF LINES 17-26)*	6,666,006			27.00
28.00	LABORATORY (SEE INSTRUCTIONS)	0	CHARGES	0	28.00
29.00	RESPIRATORY THERAPY (SEE INSTRUCTIONS)	0	CHARGES	0	29.00
30.00	OTHER ANCILLARY SERVICE COST CENTERS	0	CHARGES	0	30.00
31.00	TOTAL COSTS (SUM OF LINES 27-30)	6,666,006			31.00

* Line 17, column 1 should agree with Worksheet A, column 7 for line 74 or line 94 as appropriate, and line 27, column 1 should agree with Worksheet B, Part I, column 24, less the sum of columns 21 and 22, for line 74 or line 94 as appropriate.
6/29/2021 4:24 pm Y:\15601 - John H Stroger Jr. Hospital of Cook County\300 - Medicare Cost Report\20201130\HFS Files\2020 Stoger
MCRIF32 - 16.10.172.1

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES

Provider CCN: 14-0124

Period:

Worksheet I-2

Component CCN: 14-2313

From 12/01/2019
To 11/30/2020Date/Time Prepared:
6/29/2021 4:24 pm

		Capital Related Costs		Direct Patient Care Salary		Renal Dialysis	
		Building	Equipment	RNs	Other	Employee Benefits Department	Drugs
		1.00	2.00	3.00	4.00	5.00	6.00
1.00	Total Renal Department Costs	263,560	20,009	828,427	300,087	1,921,503	0
MAINTENANCE							
2.00	Hemodialysis	121,383	9,215	381,535	138,206	884,954	0
2.01	AKI-Hemodialysis	0	0	0	0	0	0
3.00	Intermittent Peritoneal	0	0	0	0	0	0
3.01	AKI-Intermittent Peritoneal	0	0	0	0	0	0
TRAINING							
4.00	Hemodialysis	0	0	0	0	0	0
5.00	Intermittent Peritoneal	0	0	0	0	0	0
6.00	CAPD	0	0	0	0	0	0
7.00	CCPD	0	0	0	0	0	0
HOME							
8.00	Hemodialysis	0	0	0	0	0	0
9.00	Intermittent Peritoneal	0	0	0	0	0	0
10.00	CAPD	0	0	0	0	0	0
11.00	CCPD	0	0	0	0	0	0
OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis	142,177	10,794	446,892	161,881	1,036,549	0
13.00	Method II Home Patient	0	0	0	0	0	0
14.00	ESAs (included in Renal Department)	0	0	0	0	0	0
15.00							
16.00	Other	0	0	0	0	0	0
17.00	Total (sum of lines 2 through 16)	263,560	20,009	828,427	300,087	1,921,503	0
18.00	Medical Educational Program Costs						
19.00	Total Renal Costs (line 17 + line 18)						
		Medical Supplies	Routine Ancillary Services	Subtotal (sum of cols. 1-8)	Overhead	Total (col. 9 + col. 10)	
		7.00	8.00	9.00	10.00	11.00	
1.00	Total Renal Department Costs	3,556	0	3,337,142	3,328,864	6,666,006	1.00
MAINTENANCE							
2.00	Hemodialysis	1,638	0	1,536,931	1,533,118	3,070,049	2.00
2.01	AKI-Hemodialysis	0	0	0	0	0	2.01
3.00	Intermittent Peritoneal	0	0	0	0	0	3.00
3.01	AKI-Intermittent Peritoneal	0	0	0	0	0	3.01
TRAINING							
4.00	Hemodialysis	0	0	0	0	0	4.00
5.00	Intermittent Peritoneal	0	0	0	0	0	5.00
6.00	CAPD	0	0	0	0	0	6.00
7.00	CCPD	0	0	0	0	0	7.00
HOME							
8.00	Hemodialysis	0	0	0	0	0	8.00
9.00	Intermittent Peritoneal	0	0	0	0	0	9.00
10.00	CAPD	0	0	0	0	0	10.00
11.00	CCPD	0	0	0	0	0	11.00
OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis	1,918	0	1,800,211	1,795,746	3,595,957	12.00
13.00	Method II Home Patient	0	0	0	0	0	13.00
14.00	ESAs (included in Renal Department)						14.00
15.00							15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Total (sum of lines 2 through 16)	3,556	0	3,337,142	3,328,864	6,666,006	17.00
18.00	Medical Educational Program Costs					0	18.00
19.00	Total Renal Costs (line 17 + line 18)					6,666,006	19.00

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0124

Period:

Worksheet I-3

Component CCN: 14-2313

From 12/01/2019
To 11/30/2020Date/Time Prepared:
6/29/2021 4:24 pm

		Capital Related Costs		Direct Patient Care Salary		Renal Dialysis	
		Building (Square Feet)	Equipment (%) of Time)	RNs (Hours)	Other (Hours)	Employee Benefits Department (Salary)	
	0	1.00	2.00	3.00	4.00	5.00	
1.00	Total Renal Department Costs	263,560	20,009	828,427	300,087	1,921,503	1.00
MAINTENANCE							
2.00	Hemodialysis	3,164	3,164.00	3,164.00	3,164.00	3,164	2.00
2.01	AKI-Hemodialysis	0	0.00	0.00	0.00	0	2.01
3.00	Intermittent Peritoneal	0	0.00	0.00	0.00	0	3.00
3.01	AKI-Intermittent Peritoneal	0	0.00	0.00	0.00	0	3.01
TRAINING							
4.00	Hemodialysis	0	0.00	0.00	0.00	0	4.00
5.00	Intermittent Peritoneal	0	0.00	0.00	0.00	0	5.00
6.00	CAPD	0	0.00	0.00	0.00	0	6.00
7.00	CCPD	0	0.00	0.00	0.00	0	7.00
HOME							
8.00	Hemodialysis	0	0.00	0.00	0.00	0	8.00
9.00	Intermittent Peritoneal	0	0.00	0.00	0.00	0	9.00
10.00	CAPD	0	0.00	0.00	0.00	0	10.00
11.00	CCPD	0	0.00	0.00	0.00	0	11.00
OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis Treatments	3,706	3,706.00	3,706.00	3,706.00	3,706	12.00
13.00	Method II Home Patient	0	0.00	0.00	0.00	0	13.00
14.00	ESAs						14.00
15.00							15.00
16.00	Other	0	0.00	0.00	0.00	0	16.00
17.00	Total Statistical Basis	6,870	6,870.00	6,870.00	6,870.00	6,870	17.00
18.00	Unit Cost Multiplier (line 1 ÷ line 17)	38.363901	2.912518	120.586172	43.680786	279.694760	18.00
		Drugs (Requist.)	Medical Supplies (Requist.)	Routine Ancillary Services (Charges)	Subtotal	Overhead (Accum. Cost)	
		6.00	7.00	8.00	9.00	10.00	
1.00	Total Renal Department Costs	0	3,556	0	3,337,142	3,328,864	1.00
MAINTENANCE							
2.00	Hemodialysis	0	3,164	0			2.00
2.01	AKI-Hemodialysis	0	0	0			2.01
3.00	Intermittent Peritoneal	0	0	0			3.00
3.01	AKI-Intermittent Peritoneal	0	0	0			3.01
TRAINING							
4.00	Hemodialysis	0	0	0			4.00
5.00	Intermittent Peritoneal	0	0	0			5.00
6.00	CAPD	0	0	0			6.00
7.00	CCPD	0	0	0			7.00
HOME							
8.00	Hemodialysis	0	0	0			8.00
9.00	Intermittent Peritoneal	0	0	0			9.00
10.00	CAPD	0	0	0			10.00
11.00	CCPD	0	0	0			11.00
OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis Treatments	0	3,706	0			12.00
13.00	Method II Home Patient	0	0	0			13.00
14.00	ESAs						14.00
15.00							15.00
16.00	Other	0	0	0			16.00
17.00	Total Statistical Basis	0	6,870	0		3,337,142	17.00
18.00	Unit Cost Multiplier (line 1 ÷ line 17)	0.000000	0.517613	0.000000		0.997519	18.00

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

Provider CCN: 14-0124

Period:

Worksheet I-4

Component CCN: 14-2313

From 12/01/2019
To 11/30/2020Date/Time Prepared:
6/29/2021 4:24 pm

		Rate 0		Renal Dialysis		
		Number of Total Treatments	Total Cost (from Wkst. I-2, col. 11)	Average Cost of Treatments (col. 2 ÷ col. 1)	Number of Program Treatments	Total Program Expenses (see instructions)
		1.00	2.00	3.00	4.00	5.00
1.00	Maintenance - Hemodialysis	3,164	3,070,049	970.31	454	440,521
2.00	Maintenance - Peritoneal Dialysis	0	0	0.00	0	0
3.00	Training - Hemodialysis	0	0	0.00	0	0
4.00	Training - Peritoneal Dialysis	0	0	0.00	0	0
5.00	Training - CAPD	0	0	0.00	0	0
6.00	Training - CCPD	0	0	0.00	0	0
7.00	Home Program - Hemodialysis	0	0	0.00	0	0
8.00	Home Program - Peritoneal Dialysis	0	0	0.00	0	0
		Patient Weeks			Patient Weeks	
		1.00	2.00	3.00	4.00	5.00
9.00	Home Program - CAPD	0	0	0.00	0	0
10.00	Home Program - CCPD	0	0	0.00	0	0
11.00	Totals (sum of lines 1 through 8, cols. 1 and 4) (sum of lines 1 through 10, cols. 2, 5, and 6) (see instruction)	3,164	3,070,049		454	440,521
12.00	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instruction)	3,164				
		Total Program Payment	Average Payment Rate (col. 6 ÷ col. 4)			
		6.00	7.00			
1.00	Maintenance - Hemodialysis	121,864	268.42			
2.00	Maintenance - Peritoneal Dialysis	0	0.00			
3.00	Training - Hemodialysis	0	0.00			
4.00	Training - Peritoneal Dialysis	0	0.00			
5.00	Training - CAPD	0	0.00			
6.00	Training - CCPD	0	0.00			
7.00	Home Program - Hemodialysis	0	0.00			
8.00	Home Program - Peritoneal Dialysis	0	0.00			
		6.00	7.00			
9.00	Home Program - CAPD	0	0.00			
10.00	Home Program - CCPD	0	0.00			
11.00	Totals (sum of lines 1 through 8, cols. 1 and 4) (sum of lines 1 through 10, cols. 2, 5, and 6) (see instruction)	121,864				
12.00	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instruction)					

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B		Provider CCN: 14-0124	Period: From 12/01/2019 To 11/30/2020	Worksheet I-5 Date/Time Prepared: 6/29/2021 4:24 pm
		1.00	2.00	
PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B				
1.00	Total expenses related to care of program beneficiaries (see instructions)	440,521		1.00
2.00	Total payment due (from Wkst. I-4, col. 6, line 11) (see instructions)	121,864	121,864	2.00
2.01	Total payment due (from Wkst. I-4, col. 6.01, line 11) (see instructions)			2.01
2.02	Total payment due (from Wkst. I-4, col. 6.02, line 11) (see instructions)			2.02
2.03	Total payment due (see instructions)	121,864	121,864	2.03
2.04	Outlier payments	38		2.04
3.00	Deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.00
3.01	Deductibles billed to Medicare (Part B) patients (see instructions)			3.01
3.02	Deductibles billed to Medicare (Part B) patients (see instructions)			3.02
3.03	Total deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.03
4.00	Coinsurance billed to Medicare (Part B) patients	24,373	24,373	4.00
4.01	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.01
4.02	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.02
4.03	Total coinsurance billed to Medicare (Part B) patients (see instructions)	24,373	24,373	4.03
5.00	Bad debts for deductibles and coinsurance, net of bad debt recoveries	0	0	5.00
5.01	Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2011 but before 1/1/2012			5.01
5.02	Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013			5.02
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014			5.03
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2014	0	0	5.04
5.05	Allowable bad debts (sum of lines 5 through line 5.04)	0	0	5.05
6.00	Adjusted reimbursable bad debts (see instructions)	0		6.00
7.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		7.00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions)	0	24,373	8.00
9.00	Program payment (see instructions)	0	97,491	9.00
10.00	Unrecovered from Medicare (Part B) patients (see instructions)			10.00
11.00	Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)	0		11.00
PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE				
12.00	Total allowable expenses (see instructions)	3,070,049		12.00
13.00	Total composite costs (from Wkst. I-4, col. 2, line 11)	3,070,049		13.00
14.00	Facility specific composite cost percentage (line 13 divided by line 12)	1.000000		14.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0124	Period: From 12/01/2019 To 11/30/2020	Worksheet L Parts I-III Date/Time Prepared: 6/29/2021 4:24 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,173,019	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		531,744	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)		226.34	3.00
4.00	Number of interns & residents (see instructions)		414.81	4.00
5.00	Indirect medical education percentage (see instructions)		52.70	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		618,181	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		17.09	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		51.20	8.00
9.00	Sum of lines 7 and 8		68.29	9.00
10.00	Allowable disproportionate share percentage (see instructions)		14.83	10.00
11.00	Disproportionate share adjustment (see instructions)		173,959	11.00
12.00	Total prospective capital payments (see instructions)		2,496,903	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