

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0300	Period: From 12/01/2019 To 11/30/2020	Worksheet S Parts I-III Date/Time Prepared: 6/24/2021 2:07 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date:	Time:
	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 PROVIDENT HOSPITAL (14-0300) 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	2,077,098	214,503	0	0	1.00
2.00	Subprovider - IPF	0	0	0	0	0	2.00
3.00	Subprovider - IRF	0	0	0	0	0	3.00
5.00	Swing Bed - SNF	0	0	0	0	0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	2,077,098	214,503	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: 14-0300		Period: From 12/01/2019 To 11/30/2020		Worksheet S-2 Part I Date/Time Prepared: 6/24/2021 2:07 pm				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 500 EAST 51ST STREET			PO Box:				1.00				
2.00	City: CHICAGO			State: IL		Zip Code: 60615-		County: COOK				
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
								V	XVIII			
								XIX				
Hospital and Hospital-Based Component Identification:												
3.00	Hospital			PROVIDENT HOSPITAL	140300	16974	1	10/08/1993	N	P	O	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
17.10	Hospital-Based (CORF) I											17.10
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:	To:				
							1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)						12/01/2019	11/30/2020		20.00		
21.00	Type of Control (see instructions)						13			21.00		
							1.00	2.00		3.00		
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00			
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01			
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02			
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		N	22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N		23.00			
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
				1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			402	0	0	0	450	0	24.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet S-2
Part I
Date/Time Prepared:
6/24/2021 2:07 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet S-2
Part I
Date/Time Prepared:
6/24/2021 2:07 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		
64.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet S-2
Part I
Date/Time Prepared:
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
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

6/24/2021 2:07 pm Y:\15602 - Provident Hospital of Cook County\300 - Medicare Cost Report\20201130\HFS\15602-20.mcrx

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0300	Period: From 12/01/2019 To 11/30/2020	Worksheet S-2 Part I Date/Time Prepared: 6/24/2021 2:07 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	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00	
107.00	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 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
					1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0300	Period: From 12/01/2019 To 11/30/2020	Worksheet S-2 Part I Date/Time Prepared: 6/24/2021 2:07 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:	277,428	155,000	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.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	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: 14-0300

Period:
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To 11/30/2020Worksheet S-2
Part I
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1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: COOK COUNTY	Contractor's Name: NATIONAL GOVERNMENT SERVICES, INC		Contractor's Number: 00131		141.00	
142.00	Street: 1340 S. DAMEN AVE, SUITE 215	PO Box:				142.00	
143.00	City: CHICAGO	State: IL		Zip Code: 60608		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?					Y	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	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.						146.00
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N	149.00
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
161.10	CORF		N	N	N	161.10	
						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: 14-0300	Period: From 12/01/2019 To 11/30/2020	Worksheet S-2 Part II Date/Time Prepared: 6/24/2021 2:07 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	05/31/2021	Y
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0300

Period:
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Date/Time Prepared:
6/24/2021 2:07 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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.	317-237-5500	DANR@BRADLEYCPA.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0300

Period:
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To 11/30/2020Worksheet S-2
Part II
Date/Time Prepared:
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		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PARTNER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

Health Financial Systems		PROVIDENT HOSPITAL		Non-CMS HFS Worksheet	
HFS Supplemental Information		Provider CCN: 14-0300	Period: From 12/01/2019 To 11/30/2020	Worksheet S-2 Part IX Date/Time Prepared: 6/24/2021 2:07 pm	
			Title V	Title XIX	
			1.00	2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE					
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)		N	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.01)		N	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.02)		N	Y	3.00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?		N	N	3.01
3.02	Does Title XIX transfer managed care (HMO) days from Worksheet S-3, Part I, column 7, sum of lines 2, 3, and 4 to Worksheet E-4, column 2, line 26?			Y	3.02
			Inpatient	Outpatient	
			1.00	2.00	
CRITICAL ACCESS HOSPITALS					
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)		N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)		N	N	5.00
			Title V	Title XIX	
			1.00	2.00	
RCE DISALLOWANCE					
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.05)		N	Y	6.00
PASS THROUGH COST					
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.06)		N	Y	7.00
RHC					
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		N	N	8.00
FQHC					
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		N	N	9.00
			State		
			1.00		
STATE MEDICAID FORMS					
10.00	Select the state when using state Medicaid forms.				10.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet S-3
Part I
Date/Time Prepared:
6/24/2021 2:07 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	38	13,908	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)		38	13,908	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		38	13,908	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		38				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet S-3
Part I
Date/Time Prepared:
6/24/2021 2:07 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)	331	402	3,104			1.00
2.00	HMO and other (see instructions)	151	450				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)	331	402	3,104			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	0			13.00
14.00	Total (see instructions)	331	402	3,104	6.48	326.24	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				6.48	326.24	27.00
28.00	Observation Bed Days		0	1,201			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet S-3
Part I
Date/Time Prepared:
6/24/2021 2:07 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	55	101	436	1.00
2.00 HMO and other (see instructions)			39	96		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	55	101	436	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00					25.10
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet S-3
Part II
Date/Time Prepared:
6/24/2021 2:07 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	34,588,301	0	34,588,301	678,571.00	50.97
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		3,189,713	0	3,189,713	21,674.00	147.17
4.01	Physicians - Part A - Teaching		547,227	0	547,227	3,902.00	140.24
5.00	Physician and Non Physician-Part B		6,623,445	0	6,623,445	56,605.00	117.01
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	12,548	12,548	126.00	99.59
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		494,756	0	494,756	7,769.00	63.68
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		2,489,785	0	2,489,785	58,857.00	42.30
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)		11,186,305	0	11,186,305		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		0	0	0		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		1,038,688	0	1,038,688		
22.01	Physician Part A - Teaching		179,600	0	179,600		
23.00	Physician Part B		2,245,529	0	2,245,529		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		4,397	0	4,397		
25.50	Home office wage-related (core)		392,409	0	392,409		
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: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet S-3
Part II
Date/Time Prepared:
6/24/2021 2:07 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	54,602	0	54,602	1,413.00	38.64	26.00
27.00	Administrative & General	5.00	2,888,080	0	2,888,080	59,244.00	48.75	27.00
28.00	Administrative & General under contract (see inst.)		3,955,981	0	3,955,981	74,754.00	52.92	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,077,645	0	2,077,645	34,800.00	59.70	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	970,186	0	970,186	40,508.00	23.95	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		91,164	0	91,164	3,964.00	23.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	629,837	0	629,837	12,481.00	50.46	38.00
39.00	Central Services and Supply	14.00	262,712	0	262,712	10,339.00	25.41	39.00
40.00	Pharmacy	15.00	2,666,224	0	2,666,224	53,272.00	50.05	40.00
41.00	Medical Records & Medical Records Library	16.00	124,244	0	124,244	4,855.00	25.59	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet S-3
Part III
Date/Time Prepared:
6/24/2021 2:07 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)	31,464,774	-12,548	31,452,226	696,656.00	45.15	1.00
2.00	Excluded area salaries (see instructions)	0	0	0	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)	31,464,774	-12,548	31,452,226	696,656.00	45.15	3.00
4.00	Subtotal other wages & related costs (see inst.)	2,984,541	0	2,984,541	66,626.00	44.80	4.00
5.00	Subtotal wage-related costs (see inst.)	12,617,402	0	12,617,402	0.00	40.12	5.00
6.00	Total (sum of lines 3 thru 5)	47,066,717	-12,548	47,054,169	763,282.00	61.65	6.00
7.00	Total overhead cost (see instructions)	13,720,675	0	13,720,675	295,630.00	46.41	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet S-3
Part IV
Date/Time Prepared:
6/24/2021 2:07 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)	8,952,413	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	3,355,436	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	1,178,107	9.00
10.00	Dental, Hearing and Vision Plan	159,558	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	67,213	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	427,934	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	497,952	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	15,906	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	14,654,519	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet S-3
Part V
Date/Time Prepared:
6/24/2021 2:07 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	494,756	14,654,519	1.00
2.00	Hospital	494,756	11,186,305	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	3,468,214	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0300	Period: From 12/01/2019 To 11/30/2020	Worksheet S-10 Date/Time Prepared: 6/24/2021 2:07 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)		1.023708	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		5,197,404	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		22,201,519	6.00
7.00	Medicaid cost (line 1 times line 6)		22,727,873	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)		17,530,469	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		30,944	9.00
10.00	Stand-alone CHIP charges		39,920	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		40,866	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		9,922	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)		153,635	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		189,900	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		194,402	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)		40,767	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)		17,581,158	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)	14,314,808	193,053	14,507,861
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	14,654,183	193,053	14,847,236
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)	14,654,183	193,053	14,847,236
				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)		8,446,491	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		225,480	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		346,892	27.01
28.00	Non-Medicare bad debt expense (see instructions)		8,099,599	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		8,413,036	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		23,260,272	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		40,841,430	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0300

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

Worksheet A

Date/Time Prepared:
6/24/2021 2:07 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		930,550	930,550	0	930,550	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		425,607	425,607	0	425,607	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	54,602	5,702,106	5,756,708	0	5,756,708	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,888,080	8,806,030	11,694,110	0	11,694,110	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	2,077,645	5,025,508	7,103,153	0	7,103,153	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	304,520	304,520	0	304,520	8.00
9.00	00900	HOUSEKEEPING	970,186	1,052,707	2,022,893	0	2,022,893	9.00
10.00	01000	DIETARY	0	1,278,806	1,278,806	-1,187,624	91,182	10.00
11.00	01100	CAFETERIA	0	0	0	1,187,624	1,187,624	11.00
13.00	01300	NURSING ADMINISTRATION	629,837	853,884	1,483,721	0	1,483,721	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	262,712	353,194	615,906	0	615,906	14.00
15.00	01500	PHARMACY	2,666,224	72,945	2,739,169	0	2,739,169	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	124,244	11	124,255	0	124,255	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	12,548	12,548	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	547,227	547,227	22.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,391,445	0	4,391,445	-12,548	4,378,897	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,702,324	0	3,702,324	-132,177	3,570,147	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	141,786	0	141,786	0	141,786	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,064,218	1,263	2,065,481	0	2,065,481	54.00
60.00	06000	LABORATORY	1,571,358	44,159	1,615,517	0	1,615,517	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,009,875	644	1,010,519	0	1,010,519	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	462,482	197	462,679	0	462,679	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	1,485,763	1,485,763	0	1,485,763	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,592,156	1,592,156	0	1,592,156	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	3,857,122	227	3,857,349	0	3,857,349	90.00
91.00	09100	EMERGENCY	7,714,161	56	7,714,217	-415,050	7,299,167	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
	OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0	99.10
	SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,588,301	27,930,333	62,518,634	0	62,518,634	118.00
	NONREIMBURSABLE COST CENTERS							
200.00		TOTAL (SUM OF LINES 118 through 199)	34,588,301	27,930,333	62,518,634	0	62,518,634	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0300

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

Worksheet A

Date/Time Prepared:
6/24/2021 2:07 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,637,845	2,568,395	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	804,555	1,230,162	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,028,442	14,785,150	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,058,994	17,753,104	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	7,103,153	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	304,520	8.00
9.00	00900	HOUSEKEEPING	0	2,022,893	9.00
10.00	01000	DIETARY	0	91,182	10.00
11.00	01100	CAFETERIA	0	1,187,624	11.00
13.00	01300	NURSING ADMINISTRATION	34,411	1,518,132	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	615,906	14.00
15.00	01500	PHARMACY	-94,135	2,645,034	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	124,255	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	12,548	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	-137,966	409,261	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,390,650	2,988,247	30.00
43.00	04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-1,452,328	2,117,819	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	141,786	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-364,121	1,701,360	54.00
60.00	06000	LABORATORY	-213,962	1,401,555	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,010,519	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	462,679	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	1,485,763	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,592,156	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	-857,744	2,999,605	90.00
91.00	09100	EMERGENCY	-2,613,116	4,686,051	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,440,225	72,958,859	118.00
NONREIMBURSABLE COST CENTERS					
200.00		TOTAL (SUM OF LINES 118 through 199)	10,440,225	72,958,859	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 14-0300

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

Worksheet Non-CMS W

Date/Time Prepared:
6/24/2021 2:07 pm

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
6.00	MAINTENANCE & REPAIRS	00600		6.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
21.00	I&R SERVICES-SALARY & FRINGES A	02100		21.00
22.00	I&R SERVICES-OTHER PRGM COSTS A	02200		22.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
43.00	NURSERY	04300		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
60.00	LABORATORY	06000		60.00
60.01	BLOOD LABORATORY	06001		60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD	06200		62.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PAT	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
74.00	RENAL DIALYSIS	07400		74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	08800		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	08900		89.00
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT	09200		92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	CORF	09910		99.10
SPECIAL PURPOSE COST CENTERS				
109.00	PANCREAS ACQUISITION	10900		109.00
110.00	INTESTINAL ACQUISITION	11000		110.00
111.00	ISLET ACQUISITION	11100		111.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
NONREIMBURSABLE COST CENTERS				
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

RECLASSIFICATIONS

Provider CCN: 14-0300

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

Worksheet A-6

Date/Time Prepared:
6/24/2021 2:07 pm

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - Cafeteria					
1.00	CAFETERIA	11.00	0	1,187,624	1.00
	TOTALS		0	1,187,624	
B - Intern & Residents					
1.00	I&R SERVICES-SALARY & FRINGES A	21.00	12,548		1.00
			12,548	0	
C - Teaching Salaries					
1.00	I&R SERVICES-OTHER PRGM COSTS A	22.00	547,227		1.00
2.00					2.00
			547,227	0	
500.00	Grand Total: Increases		559,775	1,187,624	500.00

RECLASSIFICATIONS

Provider CCN: 14-0300

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

Worksheet A-6

Date/Time Prepared:
6/24/2021 2:07 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - Cafeteria						
1.00	DIETARY	10.00	0	1,187,624	0	1.00
	TOTALS		0	1,187,624		
B - Intern & Residents						
1.00	ADULTS & PEDIATRICS	30.00	12,548			1.00
			12,548	0		
C - Teaching Salaries						
1.00	OPERATING ROOM	50.00	132,177			1.00
2.00	EMERGENCY	91.00	415,050			2.00
			547,227	0		
500.00	Grand Total: Decreases		559,775	1,187,624		500.00

RECLASSIFICATIONS

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
6/24/2021 2:07 pm

Increases					Decreases					
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00		
A - Cafeteria										
1.00	CAFETERIA	11.00	0	1,187,624	DIETARY	10.00	0	1,187,624		1.00
	TOTALS		0	1,187,624	TOTALS		0	1,187,624		
B - Intern & Residents										
1.00	I&R SERVICES-SALARY & FRINGES A	21.00	12,548		ADULTS & PEDIATRICS	30.00	12,548			1.00
			12,548	0			12,548	0		
C - Teaching Salaries										
1.00	I&R SERVICES-OTHER PRGM COSTS A	22.00	547,227		OPERATING ROOM	50.00	132,177			1.00
2.00					EMERGENCY	91.00	415,050			2.00
			547,227	0			547,227	0		
500.00	Grand Total: Increases		559,775	1,187,624	Grand Total: Decreases		559,775	1,187,624		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet A-7
Part I
Date/Time Prepared:
6/24/2021 2:07 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	52,214,508	3,737,630	0	3,737,630	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	108,487	74,300	0	74,300	0	5.00
6.00	Movable Equipment	4,240,428	319,089	0	319,089	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	56,563,423	4,131,019	0	4,131,019	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	56,563,423	4,131,019	0	4,131,019	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	55,952,138	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	182,787	0				5.00
6.00	Movable Equipment	4,559,517	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	60,694,442	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	60,694,442	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet A-7
Part II
Date/Time Prepared:
6/24/2021 2:07 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	930,550	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	258,768	166,839	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,189,318	166,839	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	930,550				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	425,607				2.00
3.00	Total (sum of lines 1-2)	0	1,356,157				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet A-7
Part III
Date/Time Prepared:
6/24/2021 2:07 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	56,134,925	0	56,134,925	0.924878	0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	4,559,517	0	4,559,517	0.075122	0	2.00	
3.00	Total (sum of lines 1-2)	60,694,442	0	60,694,442	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	930,550	0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	258,768	166,839	2.00	
3.00	Total (sum of lines 1-2)	0	0	0	1,189,318	166,839	3.00	
Cost Center Description		SUMMARY OF CAPITAL						
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
		11.00	12.00	13.00	14.00	15.00		
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	1,637,845	0	0	0	2,568,395	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	804,555	0	0	0	1,230,162	2.00	
3.00	Total (sum of lines 1-2)	2,442,400	0	0	0	3,798,557	3.00	

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0300

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

Worksheet A-8

Date/Time Prepared:
6/24/2021 2:07 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	-362	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0		0.00	0	3.00
4.00	Investment income - other (chapter 2)		0		0.00	0	4.00
5.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	5.00
6.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	6.00
7.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	7.00
8.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	8.00
9.00	Television and radio service (chapter 21)		0		0.00	0	9.00
10.00	Parking lot (chapter 21)	B	-136,895	ADMINISTRATIVE & GENERAL	5.00	0	10.00
11.00	Provider-based physician adjustment	A-8-2	-6,223,480			0	11.00
12.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	12.00
13.00	Related organization transactions (chapter 10)	A-8-1	5,803,194			0	13.00
14.00	Laundry and linen service		0		0.00	0	14.00
15.00	Cafeteria-employees and guests		0		0.00	0	15.00
16.00	Rental of quarters to employee and others		0		0.00	0	16.00
17.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	17.00
18.00	Sale of drugs to other than patients	B	-135,100	PHARMACY	15.00	0	18.00
19.00	Sale of medical records and abstracts		0		0.00	0	19.00
20.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	20.00
21.00	Vending machines		0		0.00	0	21.00
22.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	22.00
23.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	23.00
24.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		24.00
25.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		25.00
26.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		26.00
27.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	27.00
28.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	28.00
29.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		29.00
30.00	Physicians' assistant		0		0.00	0	30.00
30.99	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.99
31.00	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		31.00
32.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		32.00
33.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	33.00
	Misc Income	B	35	ADMINISTRATIVE & GENERAL	5.00	0	

6/24/2021 2:07 pm Y:\15602 - Provident Hospital of Cook County\300 - Medicare Cost Report\20201130\HFS\15602-20.mcrx

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0300

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

Worksheet A-8

Date/Time Prepared:
6/24/2021 2:07 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	Added Interest Capital	A	1,638,207	CAP REL COSTS-BLDG & FIXT	1.00	11	33.01
33.02	Added Interest Mvbl Equip Capital	A	804,555	CAP REL COSTS-MVBLE EQUIP	2.00	11	33.02
33.03	Added Interest Working Capital	A	685,071	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	Lobbying	A	-7,421	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	Midlevel Expense	A	-255,386	OPERATING ROOM	50.00	0	33.05
33.06	Midlevel Expense	A	-288,582	CLINIC	90.00	0	33.06
33.07	Midlevel Expense	A	-262,439	EMERGENCY	91.00	0	33.07
33.08	Pension Expense	A	8,810,161	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09	Reserve for Claims	A	8,667	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.09
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		10,440,225				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0300

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

Worksheet A-8-1

Date/Time Prepared:
6/24/2021 2:07 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	CCHHS - Human Resources	209,614	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	CCHHS - Capital	193,356	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	CCHHS - A&G	5,324,848	0	3.00
3.01	13.00	NURSING ADMINISTRATION	CCHHS - Nursing Admin	34,411	0	3.01
3.02	15.00	PHARMACY	CCHHS - Drugs	40,965	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.			5,803,194	0	5.00

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

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

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

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

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

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

Provider CCN: 14-0300

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

Worksheet A-8-1

Date/Time Prepared:
6/24/2021 2:07 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	209,614	0		1.00
2.00	193,356	0		2.00
3.00	5,324,848	0		3.00
3.01	34,411	0		3.01
3.02	40,965	0		3.02
4.00	0	0		4.00
5.00	5,803,194			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0300

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

Worksheet A-8-2

Date/Time Prepared:
6/24/2021 2:07 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	22.00	I&R SERVICES-OTHER PRGM COSTS A	547,227	0	547,227	211,500	3,902	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,616,793	1,293,434	323,359	179,000	2,542	2.00
3.00	50.00	OPERATING ROOM	1,387,853	1,156,544	231,309	246,400	1,567	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	364,121	364,121	0	0	0	4.00
5.00	60.00	LABORATORY	213,962	213,962	0	0	0	5.00
6.00	90.00	CLINIC	605,884	565,492	40,392	179,000	416	6.00
7.00	91.00	EMERGENCY	3,290,755	2,104,897	1,067,272	246,400	7,730	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			8,026,595	5,698,450	2,209,559		16,157	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	22.00	I&R SERVICES-OTHER PRGM COSTS A	396,766	19,838	0	0	12,495	1.00
2.00	30.00	ADULTS & PEDIATRICS	218,759	10,938	0	0	36,918	2.00
3.00	50.00	OPERATING ROOM	185,629	9,281	0	0	31,691	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	8,314	4.00
5.00	60.00	LABORATORY	0	0	0	0	4,886	5.00
6.00	90.00	CLINIC	35,800	1,790	0	0	13,835	6.00
7.00	91.00	EMERGENCY	915,708	45,785	0	0	75,142	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,752,662	87,632	0	0	183,281	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	22.00	I&R SERVICES-OTHER PRGM COSTS A	12,495	409,261	137,966	137,966		1.00
2.00	30.00	ADULTS & PEDIATRICS	7,384	226,143	97,216	1,390,650		2.00
3.00	50.00	OPERATING ROOM	5,282	190,911	40,398	1,196,942		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	364,121		4.00
5.00	60.00	LABORATORY	0	0	0	213,962		5.00
6.00	90.00	CLINIC	922	36,722	3,670	569,162		6.00
7.00	91.00	EMERGENCY	24,370	940,078	127,194	2,350,677		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			50,453	1,803,115	406,444	6,223,480		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet B
Part I
Date/Time Prepared:
6/24/2021 2:07 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,568,395	2,568,395			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,230,162		1,230,162		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	14,785,150	26,210	0	14,811,360	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,753,104	502,109	255,445	1,238,686	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	8,636	28,829	0	6.00
7.00	00700	OPERATION OF PLANT	7,103,153	384,789	119,419	891,094	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	304,520	0	0	0	8.00
9.00	00900	HOUSEKEEPING	2,022,893	7,475	13,229	416,109	9.00
10.00	01000	DIETARY	91,182	83,054	0	0	10.00
11.00	01100	CAFETERIA	1,187,624	37,289	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,518,132	17,727	70,071	270,135	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	615,906	12,020	8,908	112,676	14.00
15.00	01500	PHARMACY	2,645,034	16,078	3,752	1,143,533	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	124,255	57,205	0	53,288	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	12,548	0	0	5,382	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	409,261	0	0	234,703	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,988,247	285,924	191,715	1,878,091	30.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,117,819	154,769	127,578	1,531,222	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	141,786	44,003		60,811	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,701,360	171,761	315,103	885,335	54.00
60.00	06000	LABORATORY	1,401,555	136,301	15,585	673,949	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	28,779	0	65.00
66.00	06600	PHYSICAL THERAPY	1,010,519	37,996	7,541	433,131	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	18,521	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	462,679	11,833	38,043	198,357	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,485,763	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	1,592,156	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	2,999,605	405,793	3,951	1,654,304	90.00
91.00	09100	EMERGENCY	4,686,051	148,902	2,214	3,130,554	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT					92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	72,958,859	2,568,395	1,230,162	14,811,360	118.00
NONREIMBURSABLE COST CENTERS							
200.00		Cross Foot Adjustments		0	0	0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	72,958,859	2,568,395	1,230,162	14,811,360	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet B
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	19,749,344					5.00
6.00	00600	MAINTENANCE & REPAIRS	13,906	51,371				6.00
7.00	00700	OPERATION OF PLANT	3,154,295	9,731	11,662,481			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	113,026	0	0	417,546		8.00
9.00	00900	HOUSEKEEPING	912,949	189	52,943	19,416	3,445,203	9.00
10.00	01000	DIETARY	64,670	2,100	588,234	0	0	10.00
11.00	01100	CAFETERIA	454,641	943	264,100	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	696,324	448	125,550	0	571,421	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	278,190	304	85,134	349	40,774	14.00
15.00	01500	PHARMACY	1,413,532	407	113,875	0	28,211	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	87,130	1,447	405,155	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	6,655	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	239,015	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,983,481	7,230	2,025,068	258,086	1,392,847	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,459,182	3,914	1,096,155	38,894	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	91,529	1,113	311,654	94	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,140,788	4,344	1,216,506	443	141,202	54.00
60.00	06000	LABORATORY	826,723	3,447	965,358	562	53,190	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	10,682	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	552,730	961	269,111	242	14,914	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,874	468	131,176	14	5,951	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	263,864	299	83,811	81	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	551,459	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	590,948	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	1,879,436	10,261	2,874,046	53	0	90.00
91.00	09100	EMERGENCY	2,957,315	3,765	1,054,605	99,312	1,196,693	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,749,344	51,371	11,662,481	417,546	3,445,203	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	19,749,344	51,371	11,662,481	417,546	3,445,203	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet B
Part I
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	829,240					10.00
11.00	01100	CAFETERIA	0	1,944,597				11.00
13.00	01300	NURSING ADMINISTRATION	0	74,860	3,344,668			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	1,154,261		14.00
15.00	01500	PHARMACY	0	0	0	12	5,364,434	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	89,723	0	9	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	824,446	979,731	994,741	0	7,770	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	165,800	757,367	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	128,601	52,792	979	1,125	54.00
60.00	06000	LABORATORY	0	140,189	0	526	94	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	81,326	0	499	20	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	16,710	0	153	54,182	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	1,151,864	5,267,739	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	414,868	176	40	90.00
91.00	09100	EMERGENCY	4,794	267,657	1,124,900	43	33,464	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	829,240	1,944,597	3,344,668	1,154,261	5,364,434	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	829,240	1,944,597	3,344,668	1,154,261	5,364,434	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0300

Period:
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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		Subtotal	
					SERVICES-SALAR Y & FRINGES A	SERVICES-OTHER PRGM COSTS A		
			16.00	17.00	21.00	22.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	818,212					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	24,585			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0		882,979		22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	43,217	0	15,887	570,582	14,447,063	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,046	0	2,619	94,047	7,553,412	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	1,446	51,940	704,376	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	100	0	1,123	40,342	5,801,904	54.00
60.00	06000	LABORATORY	299	0	0	0	4,217,778	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	39,461	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	2,408,990	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	163,004	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	1,130,012	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	8,456,825	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,183,104	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	463,816	0	0	0	10,706,349	90.00
91.00	09100	EMERGENCY	306,734	0	3,510	126,068	15,146,581	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	818,212	0	24,585	882,979	72,958,859	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	818,212	0	24,585	882,979	72,958,859	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0300

Period:
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Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A			22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-586,469	13,860,594	30.00
43.00	04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-96,666	7,456,746	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	-53,386	650,990	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-41,465	5,760,439	54.00
60.00	06000	LABORATORY	0	4,217,778	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	39,461	65.00
66.00	06600	PHYSICAL THERAPY	0	2,408,990	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	163,004	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,130,012	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	8,456,825	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,183,104	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	10,706,349	90.00
91.00	09100	EMERGENCY	-129,578	15,017,003	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0		92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-907,564	72,051,295	118.00
NONREIMBURSABLE COST CENTERS					
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	-907,564	72,051,295	202.00

COST ALLOCATION STATISTICS

Provider CCN: 14-0300

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

Worksheet Non-CMS W

Date/Time Prepared:
6/24/2021 2:07 pm

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-1	ACCUM. COST	5.00
6.00	MAINTENANCE & REPAIRS	1	SQUARE FEET	6.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	3	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	4	HOURS OF SERVICE	9.00
10.00	DIETARY	5	MEALS SERVED	10.00
11.00	CAFETERIA	6	MEALS SERVED	11.00
13.00	NURSING ADMINISTRATION	7	DIRECT NRS ING	13.00
14.00	CENTRAL SERVICES & SUPPLY	8	COSTED REQUIS.	14.00
15.00	PHARMACY	14	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	9	TIME SPENT	16.00
17.00	SOCIAL SERVICE	10	TIME SPENT	17.00
21.00	I&R SERVICES-SALARY & FRINGES A	11	ASSIGNED TIME	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS A	12	ASSIGNED TIME	22.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet B
Part II
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	26,210	0	26,210	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	193,356	502,109	255,445	950,910	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	8,636	28,829	37,465	6.00
7.00	00700	OPERATION OF PLANT	0	384,789	119,419	504,208	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	7,475	13,229	20,704	9.00
10.00	01000	DIETARY	0	83,054	0	83,054	10.00
11.00	01100	CAFETERIA	0	37,289	0	37,289	11.00
13.00	01300	NURSING ADMINISTRATION	0	17,727	70,071	87,798	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	12,020	8,908	20,928	14.00
15.00	01500	PHARMACY	0	16,078	3,752	19,830	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	57,205	0	57,205	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	285,924	191,715	477,639	30.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	154,769	127,578	282,347	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	44,003	0	44,003	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	171,761	315,103	486,864	54.00
60.00	06000	LABORATORY	0	136,301	15,585	151,886	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	28,779	28,779	65.00
66.00	06600	PHYSICAL THERAPY	0	37,996	7,541	45,537	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	18,521	0	18,521	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	11,833	38,043	49,876	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	405,793	3,951	409,744	90.00
91.00	09100	EMERGENCY	0	148,902	2,214	151,116	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	193,356	2,568,395	1,230,162	3,991,913	118.00
NONREIMBURSABLE COST CENTERS							
200.00		Cross Foot Adjustments			0		200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	193,356	2,568,395	1,230,162	3,991,913	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0300

Period:
From 12/01/2019
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	953,102					5.00
6.00	00600	MAINTENANCE & REPAIRS	671	38,136				6.00
7.00	00700	OPERATION OF PLANT	152,237	7,224	665,246			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,455	0	0	5,455		8.00
9.00	00900	HOUSEKEEPING	44,058	140	3,020	254	68,912	9.00
10.00	01000	DIETARY	3,121	1,559	33,554	0	0	10.00
11.00	01100	CAFETERIA	21,941	700	15,065	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	33,604	333	7,162	0	11,430	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,425	226	4,856	5	816	14.00
15.00	01500	PHARMACY	68,216	302	6,496	0	564	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,205	1,074	23,111	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	321	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	11,535	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	95,721	5,368	115,513	3,372	27,860	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	70,419	2,905	62,526	508	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	4,417	826	17,777	1	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	55,054	3,224	69,391	6	2,824	54.00
60.00	06000	LABORATORY	39,897	2,559	55,066	7	1,064	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	515	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	26,674	713	15,351	3	298	66.00
67.00	06700	OCCUPATIONAL THERAPY	332	348	7,482	0	119	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	12,734	222	4,781	1	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	26,613	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,519	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	90,700	7,618	163,939	1	0	90.00
91.00	09100	EMERGENCY	142,718	2,795	60,156	1,297	23,937	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	953,102	38,136	665,246	5,455	68,912	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	953,102	38,136	665,246	5,455	68,912	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet B
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	121,288					10.00
11.00	01100	CAFETERIA	0	74,995				11.00
13.00	01300	NURSING ADMINISTRATION	0	2,887	143,692			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	40,455		14.00
15.00	01500	PHARMACY	0	0	0	0	97,432	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,460	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	120,587	37,785	42,736	0	141	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	6,394	32,538	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,960	2,268	34	20	54.00
60.00	06000	LABORATORY	0	5,407	0	18	2	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,136	0	17	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	644	0	5	984	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	40,373	95,676	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	17,823	6	1	90.00
91.00	09100	EMERGENCY	701	10,322	48,327	2	608	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	121,288	74,995	143,692	40,455	97,432	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	121,288	74,995	143,692	40,455	97,432	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0300

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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		Subtotal	
					SERVICES-SALAR Y & FRINGES A	SERVICES-OTHER PRGM COSTS A		
			16.00	17.00	21.00	22.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	89,149					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	331			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0		11,950		22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,709	0			934,755	30.00
43.00	04300	NURSERY	0	0			0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	441	0			460,788	50.00
51.00	05100	RECOVERY ROOM	0	0			0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0			0	52.00
53.00	05300	ANESTHESIOLOGY	0	0			67,132	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11	0			626,223	54.00
60.00	06000	LABORATORY	33	0			257,132	60.00
60.01	06001	BLOOD LABORATORY	0	0			0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0			0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0			29,294	65.00
66.00	06600	PHYSICAL THERAPY	0	0			92,495	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0			26,802	67.00
68.00	06800	SPEECH PATHOLOGY	0	0			0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0			69,598	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0			162,662	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0			0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0			28,519	73.00
74.00	07400	RENAL DIALYSIS	0	0			0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0			0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	89.00
90.00	09000	CLINIC	50,535	0			743,295	90.00
91.00	09100	EMERGENCY	33,420	0			480,937	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0			0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0			0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0			0	110.00
111.00	11100	ISLET ACQUISITION	0	0			0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	89,149	0	0	0	3,979,632	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments			331	11,950	12,281	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	89,149	0	331	11,950	3,991,913	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0300

Period:
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A		22.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	934,755
43.00	04300	NURSERY	0	0
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	460,788
51.00	05100	RECOVERY ROOM	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0
53.00	05300	ANESTHESIOLOGY	0	67,132
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	626,223
60.00	06000	LABORATORY	0	257,132
60.01	06001	BLOOD LABORATORY	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0
65.00	06500	RESPIRATORY THERAPY	0	29,294
66.00	06600	PHYSICAL THERAPY	0	92,495
67.00	06700	OCCUPATIONAL THERAPY	0	26,802
68.00	06800	SPEECH PATHOLOGY	0	0
69.00	06900	ELECTROCARDIOLOGY	0	69,598
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	162,662
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	28,519
74.00	07400	RENAL DIALYSIS	0	0
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0
90.00	09000	CLINIC	0	743,295
91.00	09100	EMERGENCY	0	480,937
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0
SPECIAL PURPOSE COST CENTERS				
109.00	10900	PANCREAS ACQUISITION	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0
111.00	11100	ISLET ACQUISITION	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,979,632
NONREIMBURSABLE COST CENTERS				
200.00		Cross Foot Adjustments	0	12,281
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118 through 201)	0	3,991,913

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0300

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	384,823				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		425,607			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,927	0	34,533,699		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	75,231	88,378	2,888,080	-19,749,344	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,294	9,974	0	0	6.00
7.00	00700	OPERATION OF PLANT	57,653	41,316	2,077,645	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,120	4,577	970,186	0	9.00
10.00	01000	DIETARY	12,444	0	0	0	10.00
11.00	01100	CAFETERIA	5,587	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,656	24,243	629,837	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,801	3,082	262,712	0	14.00
15.00	01500	PHARMACY	2,409	1,298	2,666,224	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,571	0	124,244	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	12,548	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	547,227	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	42,840	66,329	4,378,897	0	30.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	23,189	44,139	3,570,147	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	6,593	0	141,786	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,735	109,018	2,064,218	0	54.00
60.00	06000	LABORATORY	20,422	5,392	1,571,358	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	9,957	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,693	2,609	1,009,875	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,775	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,773	13,162	462,482	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	60,800	1,367	3,857,122	0	90.00
91.00	09100	EMERGENCY	22,310	766	7,299,111	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT					92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	384,823	425,607	34,533,699	-19,749,344	118.00
NONREIMBURSABLE COST CENTERS							
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,568,395	1,230,162	14,811,360	19,749,344	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.674224	2.890371	0.428896	0.371162	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			26,210	953,102	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000759	0.017912	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0300

Period:
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To 11/30/2020

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Date/Time Prepared:
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Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	304,371				6.00
7.00	00700	OPERATION OF PLANT	57,653	246,718			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	486,312		8.00
9.00	00900	HOUSEKEEPING	1,120	1,120	22,614	46,895	9.00
10.00	01000	DIETARY	12,444	12,444	0	0	10.00
11.00	01100	CAFETERIA	5,587	5,587	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,656	2,656	0	7,778	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,801	1,801	407	555	14.00
15.00	01500	PHARMACY	2,409	2,409	0	384	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,571	8,571	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	42,840	42,840	300,588	18,959	30.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	23,189	23,189	45,300	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	6,593	6,593	110	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,735	25,735	516	1,922	54.00
60.00	06000	LABORATORY	20,422	20,422	655	724	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,693	5,693	282	203	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,775	2,775	16	81	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,773	1,773	94	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	60,800	60,800	62	0	90.00
91.00	09100	EMERGENCY	22,310	22,310	115,668	16,289	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	304,371	246,718	486,312	46,895	118.00
NONREIMBURSABLE COST CENTERS							
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	51,371	11,662,481	417,546	3,445,203	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.168778	47.270491	0.858597	73.466318	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	38,136	665,246	5,455	68,912	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.125294	2.696382	0.011217	1.469496	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0300

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

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Date/Time Prepared:
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Cost Center Description			CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	46,316					11.00
13.00	01300	NURSING ADMINISTRATION	1,783	131,209				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,488,854			14.00
15.00	01500	PHARMACY	0	0	15	1,592,155		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,137	0	11	0	24,669	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	23,335	39,023	0	2,306	1,303	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,949	29,711	0	0	122	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,063	2,071	1,263	334	3	54.00
60.00	06000	LABORATORY	3,339	0	678	28	9	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,937	0	644	6	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	398	0	197	16,081	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	1,485,763	1,563,456	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	16,275	227	12	13,984	90.00
91.00	09100	EMERGENCY	6,375	44,129	56	9,932	9,248	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	46,316	131,209	1,488,854	1,592,155	24,669	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,944,597	3,344,668	1,154,261	5,364,434	818,212	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	41.985426	25.491148	0.775268	3.369291	33.167619	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	74,995	143,692	40,455	97,432	89,149	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.619203	1.095138	0.027172	0.061195	3.613807	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0300

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

Worksheet B-1

Date/Time Prepared:
6/24/2021 2:07 pm

Cost Center Description		INTERNS & RESIDENTS			
		SOCIAL SERVICE (TIME SPENT)	SERVICES-SALAR Y & FRINGES A	SERVICES-OTHER PRGM COSTS A	
			(ASSIGNED TIME)	(ASSIGNED TIME)	
		17.00	21.00	22.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE	0		17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	3,502	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	3,502	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	2,263	30.00
43.00	04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	373	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	206	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	160	54.00
60.00	06000	LABORATORY	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	500	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,502	118.00
NONREIMBURSABLE COST CENTERS					
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	24,585	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	7.020274	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	331	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.094517	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			207.00

Worksheet C
Part I
Date/Time Prepared:
6/24/2021 2:07 pm

6/24/2021 2:07 pm Y:\15602 - Provident Hospital of Cook County\300 - Medicare Cost Report\20201130\HFS\15602-20.mcrx

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet C
Part I
Date/Time Prepared:
6/24/2021 2:07 pm

			Title XVIII		Hospital	PPS		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,241,200		6,241,200			30.00
43.00	04300	NURSERY	0		0			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	116,061	11,285,033	11,401,094	0.654038	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	9,136	1,943,680	1,952,816	0.333360	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	423,102	7,742,095	8,165,197	0.705487	0.000000	54.00
60.00	06000	LABORATORY	745,206	8,675,421	9,420,627	0.447717	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0.000000	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	575,996	282,464	858,460	0.045967	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	30,332	608,382	638,714	3.771625	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,784	108,767	111,551	1.461251	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	212,792	1,558,253	1,771,045	0.638048	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	10,000	1,253,199	1,263,199	6.694769	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,101,378	3,107,327	4,208,705	0.518712	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	6,341	10,513,176	10,519,517	1.017761	0.000000	90.00
91.00	09100	EMERGENCY	277,316	11,169,883	11,447,199	1.311850	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	454,125	1,929,215	2,383,340	1.633807	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0			99.10
	SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
200.00		Subtotal (see instructions)	10,205,769	60,176,895	70,382,664			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,205,769	60,176,895	70,382,664			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet C
Part I
Date/Time Prepared:
6/24/2021 2:07 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
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.657581			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	0.333360			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.705487			54.00
60.00	06000 LABORATORY	0.447717			60.00
60.01	06001 BLOOD LABORATORY	0.000000			60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD	0.000000			62.00
65.00	06500 RESPIRATORY THERAPY	0.045967			65.00
66.00	06600 PHYSICAL THERAPY	3.771625			66.00
67.00	06700 OCCUPATIONAL THERAPY	1.461251			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.638048			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	6.694769			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.518712			73.00
74.00	07400 RENAL DIALYSIS	0.000000			74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000 CLINIC	1.018109			90.00
91.00	09100 EMERGENCY	1.322961			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	1.633807			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910 CORF				99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900 PANCREAS ACQUISITION				109.00
110.00	11000 INTESTINAL ACQUISITION				110.00
111.00	11100 ISLET ACQUISITION				111.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet C
Part I
Date/Time Prepared:
6/24/2021 2:07 pm

			Title XIX	Hospital	Cost			
Cost Center Description			Therapy Limit Adj.	Costs				
				Total Costs	RCE Disallowance		Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,860,594		13,860,594	97,216	13,957,810	30.00
43.00	04300	NURSERY	0		0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,456,746		7,456,746	40,398	7,497,144	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	650,990		650,990	0	650,990	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,760,439		5,760,439	0	5,760,439	54.00
60.00	06000	LABORATORY	4,217,778		4,217,778	0	4,217,778	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0		0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	39,461	0	39,461	0	39,461	65.00
66.00	06600	PHYSICAL THERAPY	2,408,990	0	2,408,990	0	2,408,990	66.00
67.00	06700	OCCUPATIONAL THERAPY	163,004	0	163,004	0	163,004	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,130,012		1,130,012	0	1,130,012	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	8,456,825		8,456,825	0	8,456,825	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,183,104		2,183,104	0	2,183,104	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	10,706,349		10,706,349	3,670	10,710,019	90.00
91.00	09100	EMERGENCY	15,017,003		15,017,003	127,194	15,144,197	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	3,893,918		3,893,918		3,893,918	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0		0		0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0		0		0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0		0	110.00
111.00	11100	ISLET ACQUISITION	0		0		0	111.00
200.00		Subtotal (see instructions)	75,945,213	0	75,945,213	268,478	76,213,691	200.00
201.00		Less Observation Beds	3,893,918		3,893,918		3,893,918	201.00
202.00		Total (see instructions)	72,051,295	0	72,051,295	268,478	72,319,773	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet C
Part I
Date/Time Prepared:
6/24/2021 2:07 pm

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,241,200		6,241,200		
43.00	04300	NURSERY	0		0		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	116,061	11,285,033	11,401,094	0.654038	0.000000
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000
53.00	05300	ANESTHESIOLOGY	9,136	1,943,680	1,952,816	0.333360	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	423,102	7,742,095	8,165,197	0.705487	0.000000
60.00	06000	LABORATORY	745,206	8,675,421	9,420,627	0.447717	0.000000
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0.000000	0.000000
65.00	06500	RESPIRATORY THERAPY	575,996	282,464	858,460	0.045967	0.000000
66.00	06600	PHYSICAL THERAPY	30,332	608,382	638,714	3.771625	0.000000
67.00	06700	OCCUPATIONAL THERAPY	2,784	108,767	111,551	1.461251	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000
69.00	06900	ELECTROCARDIOLOGY	212,792	1,558,253	1,771,045	0.638048	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	10,000	1,253,199	1,263,199	6.694769	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	1,101,378	3,107,327	4,208,705	0.518712	0.000000
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000
90.00	09000	CLINIC	6,341	10,513,176	10,519,517	1.017761	0.000000
91.00	09100	EMERGENCY	277,316	11,169,883	11,447,199	1.311850	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	454,125	1,929,215	2,383,340	1.633807	0.000000
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0		
110.00	11000	INTESTINAL ACQUISITION	0	0	0		
111.00	11100	ISLET ACQUISITION	0	0	0		
200.00		Subtotal (see instructions)	10,205,769	60,176,895	70,382,664		
201.00		Less Observation Beds					
202.00		Total (see instructions)	10,205,769	60,176,895	70,382,664		

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet C
Part I
Date/Time Prepared:
6/24/2021 2:07 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000	LABORATORY	0.000000			60.00
60.01	06001	BLOOD LABORATORY	0.000000			60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.000000			62.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION				109.00
110.00	11000	INTESTINAL ACQUISITION				110.00
111.00	11100	ISLET ACQUISITION				111.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet D
Part I
Date/Time Prepared:
6/24/2021 2:07 pm

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		934,755	0	934,755	4,305	217.13	30.00
43.00	NURSERY		0		0	0	0.00	43.00
200.00	Total (lines 30 through 199)		934,755		934,755	4,305		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		331	71,870				
43.00	NURSERY		0	0				
200.00	Total (lines 30 through 199)		331	71,870	200.00			

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet D
Part II
Date/Time Prepared:
6/24/2021 2:07 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	460,788	11,401,094	0.040416	2,457	99	50.00	
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	67,132	1,952,816	0.034377	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	626,223	8,165,197	0.076694	60,730	4,658	54.00	
60.00	06000	LABORATORY	257,132	9,420,627	0.027295	92,314	2,520	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0.000000	0	0	62.00	
65.00	06500	RESPIRATORY THERAPY	29,294	858,460	0.034124	45,260	1,544	65.00	
66.00	06600	PHYSICAL THERAPY	92,495	638,714	0.144814	5,387	780	66.00	
67.00	06700	OCCUPATIONAL THERAPY	26,802	111,551	0.240267	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	69,598	1,771,045	0.039298	51,391	2,020	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	162,662	1,263,199	0.128770	10,000	1,288	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	28,519	4,208,705	0.006776	141,827	961	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00	
90.00	09000	CLINIC	743,295	10,519,517	0.070659	0	0	90.00	
91.00	09100	EMERGENCY	480,937	11,447,199	0.042014	39,800	1,672	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	260,776	2,383,340	0.109416	77,875	8,521	92.00	
200.00		Total (lines 50 through 199)	3,305,653	64,141,464		527,041	24,063	200.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0300		Period: From 12/01/2019 To 11/30/2020		Worksheet D Part III Date/Time Prepared: 6/24/2021 2:07 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
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		4,305	0.00		331	30.00
43.00	04300	NURSERY		0		0	0.00		0	43.00
200.00		Total (lines 30 through 199)		0		4,305			331	200.00
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost				
					9.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0						
43.00	04300	NURSERY	0	0						
200.00		Total (lines 30 through 199)	0	0						

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet D
Part IV
Date/Time Prepared:
6/24/2021 2:07 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	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet D
Part IV
Date/Time Prepared:
6/24/2021 2:07 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	11,401,094	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,952,816	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	8,165,197	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	9,420,627	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	858,460	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	638,714	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	111,551	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,771,045	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	1,263,199	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,208,705	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	10,519,517	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	11,447,199	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	2,383,340	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	64,141,464		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet D
Part IV
Date/Time Prepared:
6/24/2021 2:07 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	2,457	0	1,072,523	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	99,944	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	60,730	0	835,551	0	54.00
60.00	06000 LABORATORY	0.000000	92,314	0	419,585	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD	0.000000	0	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0.000000	45,260	0	29,048	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	5,387	0	1,223	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	83	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	51,391	0	214,546	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.000000	10,000	0	27,900	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	141,827	0	212,480	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000 CLINIC	0.000000	0	0	1,087,364	0	90.00
91.00	09100 EMERGENCY	0.000000	39,800	0	636,468	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0.000000	77,875	0	208,615	0	92.00
200.00	Total (lines 50 through 199)		527,041	0	4,845,330	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet D
Part IV
Date/Time Prepared:
6/24/2021 2:07 pm

				Title XVIII	Hospital	PPS
Cost Center Description			PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
			21.00	24.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0		92.00
200.00		Total (lines 50 through 199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet D
Part V
Date/Time Prepared:
6/24/2021 2:07 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	0.654038	1,072,523	0	0	701,471	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.333360	99,944	0	0	33,317	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.705487	835,551	0	0	589,470	54.00
60.00	06000	LABORATORY	0.447717	419,585	0	0	187,855	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.000000	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.045967	29,048	0	0	1,335	65.00
66.00	06600	PHYSICAL THERAPY	3.771625	1,223	0	0	4,613	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.461251	83	0	0	121	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.638048	214,546	0	0	136,891	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	6.694769	27,900	0	0	186,784	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.518712	212,480	1,615	49,476	110,216	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC						88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000	CLINIC	1.017761	1,087,364	0	10	1,106,677	90.00
91.00	09100	EMERGENCY	1.311850	636,468	0	0	834,951	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.633807	208,615	0	0	340,837	92.00
200.00		Subtotal (see instructions)		4,845,330	1,615	49,486	4,234,538	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		4,845,330	1,615	49,486	4,234,538	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet D
Part V
Date/Time Prepared:
6/24/2021 2:07 pm

			Title XVIII		Hospital	PPS
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	838	25,664		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000	CLINIC	0	10		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0		92.00
200.00		Subtotal (see instructions)	838	25,674		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	838	25,674		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0300	Period: From 12/01/2019 To 11/30/2020	Worksheet D-1 Date/Time Prepared: 6/24/2021 2:07 pm	
		Title XVIII	Hospital	PPS	
Cost Center Description				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			4,305	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			4,305	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			3,104	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)			331	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)			13,957,810	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)			13,957,810	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)			13,957,810	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY					
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			3,242.23	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,073,178	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			1,073,178	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0300

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

Worksheet D-1

Date/Time Prepared:
6/24/2021 2:07 pm

Cost Center Description		Title XVIII		Hospital		PPS
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					461,381
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,534,559
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					71,870
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					24,063
52.00	Total Program excludable cost (sum of lines 50 and 51)					95,933
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,438,626
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					1,201
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					3,242.23
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,893,918

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0300

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

Worksheet D-1

Date/Time Prepared:
6/24/2021 2:07 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	934,755	13,957,810	0.066970	3,893,918	260,776	90.00
91.00 Nursing School cost	0	13,957,810	0.000000	3,893,918	0	91.00
92.00 Allied health cost	0	13,957,810	0.000000	3,893,918	0	92.00
93.00 All other Medical Education	0	13,957,810	0.000000	3,893,918	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0300	Period: From 12/01/2019 To 11/30/2020	Worksheet D-3 Date/Time Prepared: 6/24/2021 2:07 pm	
			Title XVIII	Hospital	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		736,100		30.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.657581	2,457	1,616	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.333360	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.705487	60,730	42,844	54.00
60.00	06000	LABORATORY	0.447717	92,314	41,331	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.000000	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.045967	45,260	2,080	65.00
66.00	06600	PHYSICAL THERAPY	3.771625	5,387	20,318	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.461251	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.638048	51,391	32,790	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	6.694769	10,000	66,948	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.518712	141,827	73,567	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	1.018109	0	0	90.00
91.00	09100	EMERGENCY	1.322961	39,800	52,654	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.633807	77,875	127,233	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		527,041	461,381	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00		Net charges (line 200 minus line 201)		527,041		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet E
Part A
Date/Time Prepared:
6/24/2021 2:07 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)			252,880	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			92,391	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)			260,392	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			0	2.04
3.00	Managed Care Simulated Payments			283,684	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			34.72	4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)			0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			11.59	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)			0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)			11.59	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			0.99	10.00
11.00	FTE count for residents in dental and podiatric programs.			5.49	11.00
12.00	Current year allowable FTE (see instructions)			6.48	12.00
13.00	Total allowable FTE count for the prior year.			4.08	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.			2.40	14.00
15.00	Sum of lines 12 through 14 divided by 3.			4.32	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			4.32	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.124424	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.179420	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.124424	21.00
22.00	IME payment adjustment (see instructions)			22,672	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			18,628	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)			-10.60	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)			22,672	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			18,628	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			9.95	30.00
31.00	Percentage of Medicaid patient days (see instructions)			27.45	31.00
32.00	Sum of lines 30 and 31			37.40	32.00
33.00	Allowable disproportionate share percentage (see instructions)			12.00	33.00
34.00	Disproportionate share adjustment (see instructions)			10,359	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0300	Period: From 12/01/2019 To 11/30/2020	Worksheet E Part A Date/Time Prepared: 6/24/2021 2:07 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)	5,991,585	5,330,723	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	4,992,986	890,886	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	5,883,872		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)	6,522,566		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)		6,541,194	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		70,463	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).		17,547	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see 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)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		6,629,204	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		6,629,204	61.00
62.00	Deductibles billed to program beneficiaries		67,276	62.00
63.00	Coinsurance billed to program beneficiaries		23,232	63.00
64.00	Allowable bad debts (see instructions)		31,763	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		20,646	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		2,728	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		6,559,342	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		0	70.93
70.94	HRR adjustment amount (see instructions)		0	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0300	Period: From 12/01/2019 To 11/30/2020	Worksheet E Part A Date/Time Prepared: 6/24/2021 2:07 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		6,559,342	71.00
71.01	Sequestration adjustment (see instructions)		54,443	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		4,427,801	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)		2,077,098	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		0	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
			Prior to 10/1	On/After 10/1
			1.00	2.00
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

CALCULATION OF DSH PAYMENT PERCENTAGE

Provider CCN: 14-0300

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

Worksheet DSH

Date/Time Prepared:
6/24/2021 2:07 pm

		Title XVIII		Hospital		PPS	
		Original .mcrcx Values	Adjusted .mcrcx Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	9.95	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	27.45	0.00			27.45	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	37.40	0.00			27.45	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	Urban				Urban	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	34.72	0.00			34.72	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	12.00	0.00			11.86	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	No				No	9.00
10.00	S-2, Line 45	No				No	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	No				No	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	402	0			402	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	0	0			0	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	450	0			450	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	0	0			0	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	852	0			852	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	3,104	0			3,104	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	0	0			0	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	3,104	0			3,104	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	27.45	0.00			27.45	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE

Provider CCN: 14-0300

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

Worksheet DSH

Date/Time Prepared:
6/24/2021 2:07 pm

		Title XVIII		Hospital		PPS	
		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	20.07		0.00	True	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	False	29.00
30.00	Line 28 or 29 as applicable		20.07		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		20.07		0.00		31.00
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
DETERMINATION OF PROVIDER TYPE							
32.00	Does the hospital qualify under the Pickle amendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE

Provider CCN: 14-0300

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

Worksheet DSH

Date/Time Prepared:
6/24/2021 2:07 pm

Title XVIII

Hospital

PPS

		Revised	
		Percentage	
		6.00	
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE		
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	11.86	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	0.00	29.00
30.00	Line 28 or 29 as applicable	11.86	30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	11.86	31.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
6/24/2021 2:07 pm

		Title XVIII		Hospital		PPS		
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	252,880	0	252,880		252,880	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	92,391	0		92,391	92,391	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	260,392	0	260,392		260,392	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	283,684	0	204,963	78,721	283,684	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.124424	0.124424	0.124424	0.124424		5.00
6.00	IME payment adjustment (see instructions)	22.00	22,672	0	16,605	6,067	22,672	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	18,628	0	13,459	5,169	18,628	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	22,672	0	16,605	6,067	22,672	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	18,628	0	13,459	5,169	18,628	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	10,359	0	7,587	2,772	10,359	11.00
11.01	Uncompensated care payments	36.00	5,883,872	0	4,992,986	890,886	5,883,872	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	6,522,566	0	5,530,450	992,116	6,522,566	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,541,194	0	5,543,909	997,285	6,541,194	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	70,463	0	62,666	7,797	70,463	16.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
6/24/2021 2:07 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	5,606,575	1,005,082	6,611,657
		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	26,720	0	19,968	6,752	26,720
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	39,609	0	39,609	0	39,609
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	0.1547	0.1547	0.1547	0.1547	
23.00	Indirect medical education adjustment (see instructions)	6.00	4,134	0	3,089	1,045	4,134
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0
26.00	Total prospective capital payments (see instructions)	12.00	70,463	0	62,666	7,797	70,463
		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: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
6/24/2021 2:07 pm

		Title XVIII		Hospital		PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	252,880	252,880		252,880	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	92,391		92,391	92,391	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	260,392	260,392		260,392	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	283,684	204,963	78,721	283,684	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.124424	0.124424	0.124424		5.00
6.00	IME payment adjustment (see instructions)	22.00	22,672	16,605	6,067	22,672	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	18,628	13,459	5,169	18,628	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	22,672	16,605	6,067	22,672	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	18,628	13,459	5,169	18,628	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	10,359	7,587	2,772	10,359	11.00
11.01	Uncompensated care payments	36.00	5,883,872	4,992,986	890,886	5,883,872	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	6,522,566	5,530,450	992,116	6,522,566	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,541,194	5,543,909	997,285	6,541,194	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	70,463	62,666	7,797	70,463	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			5,606,575	1,005,082	6,611,657	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
6/24/2021 2:07 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	26,720	19,968	6,752	26,720	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	39,609	39,609	0	39,609	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	0.1547	0.1547	0.1547		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	4,134	3,089	1,045	4,134	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	70,463	62,666	7,797	70,463	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	0	0	0	0	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0300	Period: From 12/01/2019 To 11/30/2020	Worksheet E Part B Date/Time Prepared: 6/24/2021 2:07 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		26,512	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		4,234,538	2.00
3.00	OPPS payments		1,745,563	3.00
4.00	Outlier payment (see instructions)		53,607	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		26,512	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		51,101	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)		51,101	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)		51,101	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		24,589	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		26,512	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)		1,799,170	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)		447,971	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)		1,377,711	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		48,723	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)		1,426,434	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,426,434	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		315,129	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		204,834	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		28,369	36.00
37.00	Subtotal (see instructions)		1,631,268	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)		1,631,268	40.00
40.01	Sequestration adjustment (see instructions)		13,540	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		1,403,225	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)		214,503	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0300	Period: From 12/01/2019 To 11/30/2020	Worksheet E Part B Date/Time Prepared: 6/24/2021 2:07 pm
		Title XVIII	Hospital	PPS
				Overrides
				1.00
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)			0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet E-1
Part I
Date/Time Prepared:
6/24/2021 2:07 pm

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,427,801		1,403,225	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,427,801		1,403,225	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		2,077,098		214,503	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		6,504,899		1,617,728	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.		06101		8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet E-1
Part II
Date/Time Prepared:
6/24/2021 2:07 pm

		Title XVIII	Hospital	6/24/2021 2:07 pm	PPS
				1.00	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14				1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20				6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168				7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)				10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)				32.00
				Overrides	
				1.00	
CONTRACTOR OVERRIDES					
108.00	Override of HIT payment				108.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0300		Period: From 12/01/2019 To 11/30/2020	Worksheet E-4 Date/Time Prepared: 6/24/2021 2:07 pm	
		Title XVIII		Hospital		PPS
						1.00
COMPUTATION OF TOTAL DIRECT GME AMOUNT						
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.					0.00 1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)					11.59 2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA					0.00 3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)					0.00 3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))					0.00 4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)					0.00 4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)					0.00 4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)					11.59 5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)					0.99 6.00
7.00	Enter the lesser of line 5 or line 6					0.99 7.00
		Primary Care	Other	Total		
		1.00	2.00	3.00		
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	0.71	0.71		8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	0.71	0.71		9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		5.49			10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00			10.01
11.00	Total weighted FTE count	0.00	6.20			11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	2.91			12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	2.34			13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	3.82			14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00			15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00			15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00			16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00			16.01
17.00	Adjusted rolling average FTE count	0.00	3.82			17.00
18.00	Per resident amount	128,012.14	114,222.96			18.00
19.00	Approved amount for resident costs	0	436,332	436,332		19.00
				1.00		
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00		20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00		21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00		22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00		23.00
24.00	Multiply line 22 time line 23			0		24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			436,332		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)	331	16	135	26.00	
27.00	Total Inpatient Days (see instructions)	3,104	3,104	3,104	27.00	
28.00	Ratio of inpatient days to total inpatient days	0.106637	0.005155	0.043492	28.00	
29.00	Program direct GME amount	46,529	2,249	18,977	67,755	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		157	1,328	1,485	30.00
31.00	Net Program direct GME amount				66,270	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0300	Period: From 12/01/2019 To 11/30/2020	Worksheet E-4 Date/Time Prepared: 6/24/2021 2:07 pm	
		Title XVIII	Hospital	PPS	
				1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)			1,534,559	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)			0	39.00
40.00	Primary payer payments (see instructions)			0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			1,534,559	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			4,261,050	42.00
43.00	Primary payer payments (see instructions)			0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			4,261,050	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			5,795,609	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.264780	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.735220	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			66,270	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			17,547	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			48,723	50.00

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

Provider CCN: 14-0300

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

Worksheet G

Date/Time Prepared:
6/24/2021 2:07 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	480,289,945	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	64,193,455	0	0	0	4.00
5.00 Other receivable	-219,836,426	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-105,554	0	0	0	6.00
7.00 Inventory	539,091	0	0	0	7.00
8.00 Prepaid expenses	0	0	0	0	8.00
9.00 Other current assets	0	0	0	0	9.00
10.00 Due from other funds	0	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	325,080,511	0	0	0	11.00
FIXED ASSETS					
12.00 Land	0	0	0	0	12.00
13.00 Land improvements	0	0	0	0	13.00
14.00 Accumulated depreciation	0	0	0	0	14.00
15.00 Buildings	55,952,138	0	0	0	15.00
16.00 Accumulated depreciation	-37,083,400	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	182,787	0	0	0	19.00
20.00 Accumulated depreciation	-101,450	0	0	0	20.00
21.00 Automobiles and trucks	0	0	0	0	21.00
22.00 Accumulated depreciation	0	0	0	0	22.00
23.00 Major movable equipment	4,559,517	0	0	0	23.00
24.00 Accumulated depreciation	-3,350,222	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)	20,159,370	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)	345,239,881	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	37,819,045	0	0	0	37.00
38.00 Salaries, wages, and fees payable	2,727,177	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	1,726,277	0	0	0	43.00
44.00 Other current liabilities	0	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	42,272,499	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)	42,272,499	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	302,967,382	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)	302,967,382	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	345,239,881	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0300

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

Worksheet G-1

Date/Time Prepared:
6/24/2021 2:07 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		292,076,537		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3,819,810				2.00
3.00	Total (sum of line 1 and line 2)		295,896,347		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00	OTHER ADJUSTMENTS	7,071,035		0		0	9.00
10.00	Total additions (sum of line 4-9)		7,071,035		0		10.00
11.00	Subtotal (line 3 plus line 10)		302,967,382		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)		302,967,382		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00	OTHER ADJUSTMENTS		0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
6/24/2021 2:07 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	6,241,200		6,241,200	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)	6,241,200		6,241,200	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,241,200		6,241,200	17.00
18.00	Ancillary services	3,521,107	40,521,637	44,042,744	18.00
19.00	Outpatient services	1,393,324	36,334,024	37,727,348	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	Other Patient Service Revenue	0	0	0	27.00
27.02	Capitation Revenue - Net	51,544,301	0	51,544,301	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	62,699,932	76,855,661	139,555,593	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		62,518,634		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)		62,518,634		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0300

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

Worksheet G-3

Date/Time Prepared:
6/24/2021 2:07 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	139,555,593	1.00
2.00	Less contractual allowances and discounts on patients' accounts	74,979,452	2.00
3.00	Net patient revenues (line 1 minus line 2)	64,576,141	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	62,518,634	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,057,507	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	362	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	136,895	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	135,100	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	501,493	23.00
24.00	Other	88,453	24.00
24.50	COVID-19 PHE Funding	900,000	24.50
25.00	Total other income (sum of lines 6-24)	1,762,303	25.00
26.00	Total (line 5 plus line 25)	3,819,810	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)	3,819,810	29.00

CALCULATION OF CAPITAL PAYMENT

Provider CCN: 14-0300

Period:
From 12/01/2019
To 11/30/2020Worksheet L
Parts I-III
Date/Time Prepared:
6/24/2021 2:07 pm

		Title XVIII	Hospital	PPS	
		1.00			
PART I - FULLY PROSPECTIVE METHOD					
CAPITAL FEDERAL AMOUNT					
1.00	Capital DRG other than outlier		26,720	1.00	
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01	
2.00	Capital DRG outlier payments		39,609	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)		8.48	3.00	
4.00	Number of interns & residents (see instructions)		4.32	4.00	
5.00	Indirect medical education percentage (see instructions)		15.47	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)		4,134	6.00	
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00	
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00	
9.00	Sum of lines 7 and 8		0.00	9.00	
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00	
11.00	Disproportionate share adjustment (see instructions)		0	11.00	
12.00	Total prospective capital payments (see instructions)		70,463	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	