

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0124	Period: From 12/01/2020 To 11/30/2021	Worksheet S Parts I-III Date/Time Prepared: 5/2/2022 12:01 pm
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 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	Date: 5/2/2022 Time: 12:01 pm 5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 06/30/2021 7. Contractor No. 06101 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 BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)
 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 submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by JOHN H. STROGER JR. HOSP OF COOK CTY (14-0124) for the cost reporting period beginning 12/01/2020 and ending 11/30/2021 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.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2		
1	Pamela Cassara	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Pamela Cassara		2
3	Signatory Title	CHIEF FINANCIAL OFFICER		3
4	Date	(Dated when report is electronica		4

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	23,801,760	-1,654,053	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing Bed - SNF	0	0	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
200.00 Total	0	23,801,760	-1,654,053	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0124		Period: From 12/01/2020 To 11/30/2021		Worksheet S-2 Part I Date/Time Prepared: 5/2/2022 12:01 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 1901 WEST HARRISON STREET			PO Box:				1.00	
2.00	City: CHICAGO			State: IL		Zip Code: 60612-3714		County: COOK	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			JOHN H. STROGER JR. HOSP OF COOK CTY	140124	16984	1	07/01/1966	N P O
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis			JOHN H. STROGER JR. HOSP DIALYSIS	142313	16974		07/01/1973	
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						12/01/2020	11/30/2021	20.00
21.00	Type of Control (see instructions)						9		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? 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	22.04
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet S-2
Part I
Date/Time Prepared:
5/2/2022 12:01 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	
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.	11,510	0	0	0	29,694	0	24.00
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)					Y	Y	40.00
						V	XVIII	XIX
						1.00	2.00	3.00
Prospective Payment System (PPS)-Capital								
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	Y	N
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals								
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					Y	Y	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0124		Period: From 12/01/2020 To 11/30/2021		Worksheet S-2 Part I Date/Time Prepared: 5/2/2022 12:01 pm	
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	Y	Y			60.00	
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1		60.01	
		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	
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
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
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>							
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet S-2
Part I
Date/Time Prepared:
5/2/2022 12:01 pm

			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00	
		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	
		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	
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

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			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
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0124		Period: From 12/01/2020 To 11/30/2021		Worksheet S-2 Part I Date/Time Prepared: 5/2/2022 12:01 pm	
				V	XIX		
				1.00	2.00		
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.						109.00
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N			110.00
						1.00	
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
				1.00	2.00	3.00	
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.			N			0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.			N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.			N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			1			118.00
				Premiums	Losses	Insurance	
				1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:			2,511,193	48,050,000		0118.01
				1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.			N			118.02
119.00	DO NOT USE THIS LINE						119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.			N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.			Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.			N			122.00
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0124		Period: From 12/01/2020 To 11/30/2021		Worksheet S-2 Part I Date/Time Prepared: 5/2/2022 12:01 pm	
		1.00		2.00			
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	
		1.00		2.00		3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: COOK COUNTY	Contractor's Name: COOK COUNTY		Contractor's Number: 00131		141.00	
142.00	Street: 1340 S. DAMEN AVENUE	PO Box: SUITE 215				142.00	
143.00	City: CHICAGO	State: IL		Zip Code: 60608		143.00	
		1.00		2.00			
144.00	Are provider based physicians' costs included in worksheet A?	Y				144.00	
		1.00		2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N		Y		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
		1.00		2.00			
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	
		1.00		2.00		3.00	
		Title XIX		4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
		1.00		2.00			
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	
		0		1.00		2.00	
		Zip Code		CBSA		FTE/Campus	
		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)					0.00 166.00	
		1.00		2.00			
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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0124	Period: From 12/01/2020 To 11/30/2021	Worksheet S-2 Part I Date/Time Prepared: 5/2/2022 12:01 pm
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0124	Period: From 12/01/2020 To 11/30/2021	Worksheet S-2 Part II Date/Time Prepared: 5/2/2022 12:01 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)	N		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 a nursing program? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	Y		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	Y		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N 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	02/09/2022	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: 14-0124		Period: From 12/01/2020 To 11/30/2021		Worksheet S-2 Part II Date/Time Prepared: 5/2/2022 12:01 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.	XXXXXXXXXX		XXXXXXXXXX		41.00	
42.00	Enter the employer/company name of the cost report preparer.	XXXXXXXXXX				42.00	
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	XXXXXXXXXX		XXXXXXXXXX		43.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet S-2
Part II
Date/Time Prepared:
5/2/2022 12:01 pm

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	XXXXXXXXXX	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet S-3
Part I
Date/Time Prepared:
5/2/2022 12:01 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	295	107,675	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)		295	107,675	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	32	11,680	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT	33.00	8	2,920	0.00	0	10.00
11.00 SURGICAL INTENSIVE CARE UNIT	34.00	14	5,110	0.00	0	11.00
11.01 PEDIATRIC INTENSIVE CARE UNIT	34.01	0	0	0.00	0	11.01
11.02 TRAUMA INTENSIVE CARE UNIT	34.02	12	4,380	0.00	0	11.02
11.03 NEURO INTENSIVE CARE	34.03	10	3,650	0.00	0	11.03
11.04 NEONATAL INTENSIVE CARE UNIT	34.04	52	18,980	0.00	0	11.04
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		423	154,395	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		423				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		9	3,285			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet S-3
Part I
Date/Time Prepared:
5/2/2022 12:01 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	6,193	7,900	59,851			1.00
2.00 HMO and other (see instructions)	6,803	29,694				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	6,193	7,900	59,851			7.00
8.00 INTENSIVE CARE UNIT	1,087	1,931	8,962			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT	76	105	1,647			10.00
11.00 SURGICAL INTENSIVE CARE UNIT	224	252	3,028			11.00
11.01 PEDIATRIC INTENSIVE CARE UNIT	0	0	0			11.01
11.02 TRAUMA INTENSIVE CARE UNIT	124	358	2,972			11.02
11.03 NEURO INTENSIVE CARE	201	170	2,419			11.03
11.04 NEONATAL INTENSIVE CARE UNIT	0	418	4,164			11.04
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		375	1,347			13.00
14.00 Total (see instructions)	7,905	11,509	84,390	435.70	4,327.47	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)			0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				435.70	4,327.47	27.00
28.00 Observation Bed Days		0	12,428			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	860			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00
33.01 LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet S-3
Part I
Date/Time Prepared:
5/2/2022 12:01 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,314	1,879	15,950	1.00
2.00 HMO and other (see instructions)			1,052	5,471		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
11.01 PEDIATRIC INTENSIVE CARE UNIT						11.01
11.02 TRAUMA INTENSIVE CARE UNIT						11.02
11.03 NEURO INTENSIVE CARE						11.03
11.04 NEONATAL INTENSIVE CARE UNIT						11.04
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,314	1,879	15,950	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet S-3
Part II
Date/Time Prepared:
5/2/2022 12:01 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	439,901,744	0	439,901,744	8,886,820.00	49.50
2.00	Non-physician anesthetist Part A		200,325	0	200,325	2,051.00	97.67
3.00	Non-physician anesthetist Part B		2,016,624	0	2,016,624	20,170.00	99.98
4.00	Physician-Part A - Administrative		24,734,437	0	24,734,437	167,535.00	147.64
4.01	Physicians - Part A - Teaching		9,832,087	0	9,832,087	64,764.00	151.81
5.00	Physician and Non Physician-Part B		115,377,580	0	115,377,580	914,495.00	126.17
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	25,205,732	1,561,170	26,766,902	862,376.00	31.04
7.01	Contracted interns and residents (in an approved programs)		498,840	0	498,840	11,980.00	41.64
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		0	2,536,169	2,536,169	17,687.00	143.39
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		21,966,398	0	21,966,398	380,648.00	57.71
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		33,953,169	0	33,953,169	670,153.00	50.66
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)		147,703,889	0	147,703,889		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		1,034,516	0	1,034,516		
20.00	Non-physician anesthetist Part A		82,723	0	82,723		
21.00	Non-physician anesthetist Part B		828,138	0	828,138		
22.00	Physician Part A - Administrative		9,361,850	0	9,361,850		
22.01	Physician Part A - Teaching		3,703,749	0	3,703,749		
23.00	Physician Part B		44,950,851	0	44,950,851		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		16,675,425	0	16,675,425		
25.50	Home office wage-related (core)		13,302,808	0	13,302,808		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet S-3
Part II
Date/Time Prepared:
5/2/2022 12:01 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	2,134,033	0	2,134,033	41,815.00	51.04	26.00
27.00	Administrative & General	5.00	30,410,929	-1,925,275	28,485,654	796,776.00	35.75	27.00
28.00	Administrative & General under contract (see inst.)		20,448,375	0	20,448,375	386,329.00	52.93	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	12,916,806	0	12,916,806	278,961.00	46.30	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	6,757,988	0	6,757,988	326,013.00	20.73	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	3,567,947	-2,945,618	622,329	19,177.00	32.45	34.00
35.00	Dietary under contract (see instructions)		2,559,543	0	2,559,543	117,894.00	21.71	35.00
36.00	Cafeteria	11.00	0	2,945,618	2,945,618	85,410.00	34.49	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	5,279,672	0	5,279,672	96,998.00	54.43	38.00
39.00	Central Services and Supply	14.00	3,943,642	0	3,943,642	146,695.00	26.88	39.00
40.00	Pharmacy	15.00	0	19,984,627	19,984,627	420,425.00	47.53	40.00
41.00	Medical Records & Medical Records Library	16.00	4,061,403	0	4,061,403	115,011.00	35.31	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet S-3
Part III
Date/Time Prepared:
5/2/2022 12:01 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)	309,778,474	-1,561,170	308,217,304	7,515,207.00	41.01	1.00
2.00	Excluded area salaries (see instructions)	0	2,536,169	2,536,169	17,687.00	143.39	2.00
3.00	Subtotal salaries (line 1 minus line 2)	309,778,474	-4,097,339	305,681,135	7,497,520.00	40.77	3.00
4.00	Subtotal other wages & related costs (see inst.)	55,919,567	0	55,919,567	1,050,801.00	53.22	4.00
5.00	Subtotal wage-related costs (see inst.)	170,368,547	0	170,368,547	0.00	55.73	5.00
6.00	Total (sum of lines 3 thru 5)	536,066,588	-4,097,339	531,969,249	8,548,321.00	62.23	6.00
7.00	Total overhead cost (see instructions)	92,080,338	18,059,352	110,139,690	2,831,504.00	38.90	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0124	Period: From 12/01/2020 To 11/30/2021	Worksheet S-3 Part IV Date/Time Prepared: 5/2/2022 12:01 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)		131,349,150	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		2,647,791	6.00
7.00	Employee Managed Care Program Administration Fees		1,153,099	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)		56,904,392	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		18,569,677	9.00
10.00	Dental, Hearing and Vision Plan		2,556,828	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		661,893	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		3,101,916	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		0	17.00
18.00	Medicare Taxes - Employers Portion Only		6,276,478	18.00
19.00	Unemployment Insurance		176,017	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		943,900	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		224,341,141	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: 14-0124

 Period:
 From 12/01/2020
 To 11/30/2021

 Worksheet S-3
 Part V
 Date/Time Prepared:
 5/2/2022 12:01 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	21,966,398	220,593,745	1.00
2.00	Hospital	21,966,398	147,703,889	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	72,889,856	18.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021

Worksheet S-5

Date/Time Prepared:
5/2/2022 12:01 pm

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

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021

Worksheet S-5

Date/Time Prepared:
5/2/2022 12:01 pm

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0124	Period: From 12/01/2020 To 11/30/2021	Worksheet S-10 Date/Time Prepared: 5/2/2022 12:01 pm
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.770321 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	72,230,398		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0		5.00
6.00	Medicaid charges	443,751,147		6.00
7.00	Medicaid cost (line 1 times line 6)	341,830,827		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)	269,600,429		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP	1,141,924		9.00
10.00	Stand-alone CHIP charges	2,462,671		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	1,897,047		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	755,123		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)	32,238,606		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	45,322,182		14.00
15.00	State or local indigent care program cost (line 1 times line 14)	34,912,629		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	2,674,023		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)	273,029,575		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)	220,321,325	0	220,321,325 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	169,718,143	0	169,718,143 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0 22.00
23.00	Cost of charity care (line 21 minus line 22)	169,718,143	0	169,718,143 23.00
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	141,662,474		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	1,714,442		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	2,637,602		27.01
28.00	Non-Medicare bad debt expense (see instructions)	139,024,872		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	108,016,938		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	277,735,081		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	550,764,656		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021

Worksheet A

Date/Time Prepared:
5/2/2022 12:01 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		15,800,354	15,800,354	0	15,800,354 1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		8,045,333	8,045,333	0	8,045,333 2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0 3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,134,033	88,563,093	90,697,126	0	90,697,126 4.00
5.00	00500	ADMINISTRATIVE & GENERAL	30,410,929	152,806,608	183,217,537	-1,925,275	181,292,262 5.00
7.00	00700	OPERATION OF PLANT	12,916,806	23,174,389	36,091,195	0	36,091,195 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,143,179	1,143,179	0	1,143,179 8.00
9.00	00900	HOUSEKEEPING	6,757,988	3,302,466	10,060,454	0	10,060,454 9.00
10.00	01000	DIETARY	3,567,947	3,943,038	7,510,985	-6,200,903	1,310,082 10.00
11.00	01100	CAFETERIA	0	0	0	6,200,903	6,200,903 11.00
13.00	01300	NURSING ADMINISTRATION	5,279,672	4,062,106	9,341,778	0	9,341,778 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,943,642	10,926,440	14,870,082	0	14,870,082 14.00
15.00	01500	PHARMACY	0	0	0	26,591,818	26,591,818 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,061,403	3,994,363	8,055,766	0	8,055,766 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0 17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	25,205,732	2,704,468	27,910,200	1,561,170	29,471,370 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	2,005,669	7,598	2,013,267	9,942,529	11,955,796 22.00
23.00	02300	ALLIED HEALTH	0	0	0	210,920	210,920 23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	54,390,314	3,698,066	58,088,380	-889,502	57,198,878 30.00
31.00	03100	INTENSIVE CARE UNIT	6,719,743	0	6,719,743	0	6,719,743 31.00
33.00	03300	BURN INTENSIVE CARE UNIT	3,163,423	0	3,163,423	0	3,163,423 33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	3,868,257	0	3,868,257	-118,436	3,749,821 34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	0 34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	6,646,708	454,761	7,101,469	-408,361	6,693,108 34.02
34.03	02400	NEURO INTENSIVE CARE	2,005,699	0	2,005,699	0	2,005,699 34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	4,792,574	0	4,792,574	0	4,792,574 34.04
43.00	04300	NURSERY	2,314,861	0	2,314,861	0	2,314,861 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	25,537,778	15,899,778	41,437,556	-378,190	41,059,366 50.00
51.00	05100	RECOVERY ROOM	3,303,993	0	3,303,993	-32,557	3,271,436 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,515,707	0	3,515,707	0	3,515,707 52.00
53.00	05300	ANESTHESIOLOGY	11,708,110	496,535	12,204,645	-1,355,659	10,848,986 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,624,388	11,882,006	32,506,394	-758,319	31,748,075 54.00
60.00	06000	LABORATORY	11,676,292	17,986,383	29,662,675	-84,147	29,578,528 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	861,267	2,294,453	3,155,720	0	3,155,720 62.00
65.00	06500	RESPIRATORY THERAPY	3,118,835	1,858,081	4,976,916	0	4,976,916 65.00
66.00	06600	PHYSICAL THERAPY	2,935,611	237,974	3,173,585	0	3,173,585 66.00
67.00	06700	OCCUPATIONAL THERAPY	916,992	74,317	991,309	0	991,309 67.00
68.00	06800	SPEECH PATHOLOGY	525,390	260,084	785,474	0	785,474 68.00
69.00	06900	ELECTROCARDIOLOGY	2,586,584	3,718,043	6,304,627	-83,485	6,221,142 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	19,690,051	19,690,051	-6,512,358	13,177,693 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,602,153	6,602,153 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,195,547	86,261,916	106,457,463	-26,892,533	79,564,930 73.00
74.00	07400	RENAL DIALYSIS	4,328,588	165,180	4,493,768	-98,941	4,394,827 74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	117,290,273	11,609,646	128,899,919	-6,054,545	122,845,374 90.00
91.00	09100	EMERGENCY	30,590,989	13,374	30,604,363	-1,641,531	28,962,832 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		0	0	0	0 113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	439,901,744	495,074,083	934,975,827	-2,325,249	932,650,578 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
190.03	19003	SPECIAL FUNDS	0	0	0	2,325,249	2,325,249 190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0 190.04
194.00	07950	COUNTYCARE	0	0	0	0	0 194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	439,901,744	495,074,083	934,975,827	0	934,975,827 200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021

Worksheet A

Date/Time Prepared:
5/2/2022 12:01 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	35,954,695	51,755,049	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	10,164,713	18,210,046	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	148,327,649	239,024,775	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	44,799,547	226,091,809	5.00
7.00	00700	OPERATION OF PLANT	-2,153,238	33,937,957	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,143,179	8.00
9.00	00900	HOUSEKEEPING	0	10,060,454	9.00
10.00	01000	DIETARY	0	1,310,082	10.00
11.00	01100	CAFETERIA	0	6,200,903	11.00
13.00	01300	NURSING ADMINISTRATION	937,541	10,279,319	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,870,082	14.00
15.00	01500	PHARMACY	0	26,591,818	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	23,390	8,079,156	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	29,471,370	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	-3,579,858	8,375,938	22.00
23.00	02300	ALLIED HEALTH	0	210,920	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-18,036,217	39,162,661	30.00
31.00	03100	INTENSIVE CARE UNIT	0	6,719,743	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	3,163,423	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	-835,274	2,914,547	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	-2,324,679	4,368,429	34.02
34.03	02400	NEURO INTENSIVE CARE	0	2,005,699	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	-407,590	4,384,984	34.04
43.00	04300	NURSERY	0	2,314,861	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-11,604,736	29,454,630	50.00
51.00	05100	RECOVERY ROOM	-345,108	2,926,328	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-279,881	3,235,826	52.00
53.00	05300	ANESTHESIOLOGY	-9,403,620	1,445,366	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-8,041,546	23,706,529	54.00
60.00	06000	LABORATORY	-3,368,735	26,209,793	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	3,155,720	62.00
65.00	06500	RESPIRATORY THERAPY	-357,085	4,619,831	65.00
66.00	06600	PHYSICAL THERAPY	0	3,173,585	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	991,309	67.00
68.00	06800	SPEECH PATHOLOGY	0	785,474	68.00
69.00	06900	ELECTROCARDIOLOGY	-324,395	5,896,747	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	13,177,693	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,602,153	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	350,261	79,915,191	73.00
74.00	07400	RENAL DIALYSIS	-2,570,377	1,824,450	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-55,646,305	67,199,069	90.00
91.00	09100	EMERGENCY	-8,283,636	20,679,196	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	112,995,516	1,045,646,094	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	190.00
190.03	19003	SPECIAL FUNDS	0	2,325,249	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	190.04
194.00	07950	COUNTYCARE	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	112,995,516	1,047,971,343	200.00

RECLASSIFICATIONS

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021

Worksheet A-6

Date/Time Prepared:
5/2/2022 12:01 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	C - SAL OF NON RESIDENTS					
1.00	I&R SERVICES-OTHER PRGM	22.00	1,282,387	0		1.00
	COSTS APPRV					
	TOTALS		1,282,387	0		
	D - PEDS ALGY & PSYCH TO INP					
1.00	ADULTS & PEDIATRICS	30.00	330,010	0		1.00
	TOTALS		330,010	0		
	E - REGISTRY AND IN-HOUSE NSG					
1.00	CLINIC	90.00	0	1,385,992		1.00
2.00	BURN INTENSIVE CARE UNIT			0		2.00
3.00	SURGICAL INTENSIVE CARE UNIT					3.00
4.00	TRAUMA INTENSIVE CARE UNIT					4.00
5.00	NEURO INTENSIVE CARE					5.00
6.00	DELIVERY ROOM & LABOR ROOM					6.00
7.00	EMERGENCY					7.00
	TOTALS		0	1,385,992		
	F - DIETARY/CAFETERIA					
1.00	CAFETERIA	11.00	2,945,618	3,255,285		1.00
	TOTALS		2,945,618	3,255,285		
	G - HBP RESEARCH TIME					
1.00	SPECIAL FUNDS	190.03	2,325,249	0		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
	TOTALS		2,325,249	0		
	H - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO	72.00	0	6,602,153		1.00
	PATIENTS					
	TOTALS		0	6,602,153		
	I - HBP TEACHING TIME					
1.00	I&R SERVICES-OTHER PRGM	22.00	9,832,086	0		1.00
	COSTS APPRV					
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
	TOTALS		9,832,086	0		
	L - PHARMACY SCHOOL					
1.00	ALLIED HEALTH	23.00	210,920	0		1.00
	TOTALS		210,920	0		
	M - CHIEF MEDICAL OFFICER					
1.00	ADMINISTRATIVE & GENERAL	5.00	475,014	0		1.00
	TOTALS		475,014	0		
	N - I&R SALARIES					
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	2,843,557	0		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	TOTALS		2,843,557	0		
	O - TRANSPORTER SALARIES					
1.00	ADULTS & PEDIATRICS	30.00	1,764,038	0		1.00
	TOTALS		1,764,038	0		
	P - MEDICAL DIRECTORS AMBULATORY					
1.00	CLINIC	90.00	636,251	0		1.00
	TOTALS		636,251	0		
	Q - PHARMACY NON-DRUG COSTS					
1.00	PHARMACY	15.00	19,984,627	6,607,191		1.00
2.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	89,795		2.00
	PATIENT					
	TOTALS		19,984,627	6,696,986		

RECLASSIFICATIONS

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021

Worksheet A-6

Date/Time Prepared:
5/2/2022 12:01 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
1.00	R - OTHER MEDICAL DIRECTORS					
	ADULTS & PEDIATRICS	30.00	696,930	0		1.00
	TOTALS		696,930	0		
500.00	Grand Total: Increases		43,326,687	17,940,416		500.00

RECLASSIFICATIONS

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021

Worksheet A-6

Date/Time Prepared:
5/2/2022 12:01 pm

	Decreases						5/2/2022 12:01 pm
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	C - SAL OF NON RESIDENTS						
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	1,282,387	0	0		1.00
	TOTALS		1,282,387	0			
	D - PEDS ALGY & PSYCH TO INP						
1.00	CLINIC	90.00	330,010	0	0		1.00
	TOTALS		330,010	0			
	E - REGISTRY AND IN-HOUSE NSG						
1.00	ADULTS & PEDIATRICS	30.00	0	1,385,992	0		1.00
2.00							2.00
3.00							3.00
4.00							4.00
5.00							5.00
6.00							6.00
7.00							7.00
	TOTALS		0	1,385,992			
	F - DIETARY/CAFETERIA						
1.00	DIETARY	10.00	2,945,618	3,255,285	0		1.00
	TOTALS		2,945,618	3,255,285			
	G - HBP RESEARCH TIME						
1.00	ADULTS & PEDIATRICS	30.00	601,921	0	0		1.00
2.00	TRAUMA INTENSIVE CARE UNIT	34.02	164,261	0	0		2.00
3.00	OPERATING ROOM	50.00	61,648	0	0		3.00
4.00	ANESTHESIOLOGY	53.00	118,994	0	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	5,301	0	0		5.00
6.00	RENAL DIALYSIS	74.00	32,980	0	0		6.00
7.00	CLINIC	90.00	1,201,316	0	0		7.00
8.00	EMERGENCY	91.00	138,828	0	0		8.00
	TOTALS		2,325,249	0			
	H - IMPLANTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	6,602,153	0		1.00
	TOTALS		0	6,602,153			
	I - HBP TEACHING TIME						
1.00	ADULTS & PEDIATRICS	30.00	1,692,567	0	0		1.00
2.00	SURGICAL INTENSIVE CARE UNIT	34.00	118,436	0	0		2.00
3.00	TRAUMA INTENSIVE CARE UNIT	34.02	244,100	0	0		3.00
4.00	OPERATING ROOM	50.00	316,542	0	0		4.00
5.00	RECOVERY ROOM	51.00	32,557	0	0		5.00
6.00	ANESTHESIOLOGY	53.00	1,236,665	0	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	682,579	0	0		7.00
8.00	LABORATORY	60.00	84,147	0	0		8.00
9.00	RENAL DIALYSIS	74.00	65,961	0	0		9.00
10.00	CLINIC	90.00	3,981,817	0	0		10.00
11.00	EMERGENCY	91.00	1,376,715	0	0		11.00
	TOTALS		9,832,086	0			
	L - PHARMACY SCHOOL						
1.00	DRUGS CHARGED TO PATIENTS	73.00	210,920	0	0		1.00
	TOTALS		210,920	0			
	M - CHIEF MEDICAL OFFICER						
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	475,014	0	0		1.00
	TOTALS		475,014	0			
	N - I&R SALARIES						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	70,439	0	0		1.00
2.00	ELECTROCARDIOLOGY	69.00	83,485	0	0		2.00
3.00	CLINIC	90.00	2,563,645	0	0		3.00
4.00	EMERGENCY	91.00	125,988	0	0		4.00
	TOTALS		2,843,557	0			
	O - TRANSPORTER SALARIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	1,764,038	0	0		1.00
	TOTALS		1,764,038	0			
	P - MEDICAL DIRECTORS AMBULATORY						
1.00	ADMINISTRATIVE & GENERAL	5.00	636,251	0	0		1.00
	TOTALS		636,251	0			
	Q - PHARMACY NON-DRUG COSTS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	19,984,627	6,696,986	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		19,984,627	6,696,986			
	R - OTHER MEDICAL DIRECTORS						
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	696,930	0	0		1.00
	TOTALS		696,930	0			
500.00	Grand Total: Decreases		43,326,687	17,940,416			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet A-7
Part I
Date/Time Prepared:
5/2/2022 12:01 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	990,911	0	0	0	0	1.00	
2.00	Land Improvements	2,631,393	0	0	0	0	2.00	
3.00	Buildings and Fixtures	842,463,188	0	0	0	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	13,838,437	0	0	0	0	5.00	
6.00	Movable Equipment	177,511,200	0	0	0	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	1,037,435,129	0	0	0	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	1,037,435,129	0	0	0	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	990,911	0				1.00	
2.00	Land Improvements	2,631,393	0				2.00	
3.00	Buildings and Fixtures	842,463,188	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	13,838,437	0				5.00	
6.00	Movable Equipment	177,511,200	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	1,037,435,129	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	1,037,435,129	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet A-7
Part II
Date/Time Prepared:
5/2/2022 12:01 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	15,800,354	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8,045,333	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	23,845,687	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	15,800,354				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	8,045,333				2.00
3.00	Total (sum of lines 1-2)	0	23,845,687				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet A-7
Part III
Date/Time Prepared:
5/2/2022 12:01 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	842,463,188	0	842,463,188	0.825965	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	177,511,200	0	177,511,200	0.174035	0	2.00
3.00	Total (sum of lines 1-2)	1,019,974,388	0	1,019,974,388	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	15,353,078	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	8,045,333	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	23,398,411	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	36,401,971	0	0	0	51,755,049	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	10,164,713	0	0	0	18,210,046	2.00
3.00	Total (sum of lines 1-2)	46,566,684	0	0	0	69,965,095	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021

Worksheet A-8

Date/Time Prepared:
5/2/2022 12:01 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	-6,508	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)						
3.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)						
4.00	Investment income - other (chapter 2)						
5.00	Trade, quantity, and time discounts (chapter 8)						
6.00	Refunds and rebates of expenses (chapter 8)						
7.00	Rental of provider space by suppliers (chapter 8)						
8.00	Telephone services (pay stations excluded) (chapter 21)						
9.00	Television and radio service (chapter 21)						
10.00	Parking lot (chapter 21)	B	-2,153,238	OPERATION OF PLANT	7.00		9.00
11.00	Provider-based physician adjustment	A-8-2	-112,660,104				10.00
12.00	Sale of scrap, waste, etc. (chapter 23)						11.00
13.00	Related organization transactions (chapter 10)	A-8-1	59,261,799				12.00
14.00	Laundry and linen service						13.00
15.00	Cafeteria-employees and guests						14.00
16.00	Rental of quarters to employee and others						15.00
17.00	Sale of medical and surgical supplies to other than patients						16.00
18.00	Sale of drugs to other than patients	B	-307,775	DRUGS CHARGED TO PATIENTS	73.00		17.00
19.00	Sale of medical records and abstracts	B	23,390	MEDICAL RECORDS & LIBRARY	16.00		18.00
20.00	Nursing and allied health education (tuition, fees, books, etc.)						19.00
21.00	Vending machines						20.00
22.00	Income from imposition of interest, finance or penalty charges (chapter 21)						21.00
23.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments						22.00
24.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		RESPIRATORY THERAPY	65.00		23.00
25.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY	66.00		24.00
26.00	Utilization review - physicians' compensation (chapter 21)			*** Cost Center Deleted ***	114.00		25.00
27.00	Depreciation - CAP REL COSTS-BLDG & FIXT						26.00
28.00	Depreciation - CAP REL COSTS-MVBLE EQUIP						27.00
29.00	Non-physician Anesthetist			*** Cost Center Deleted ***	19.00		28.00
30.00	Physicians' assistant						29.00
30.99	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67.00		30.00
31.00	Hospice (non-distinct) (see instructions)						30.99
31.99	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest						32.00
33.00	MISCELLANEOUS INCOME	B	-10,567,796	ADMINISTRATIVE & GENERAL	5.00		33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021

Worksheet A-8

Date/Time Prepared:
5/2/2022 12:01 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.01	RESIDENCY PROGRAM REIMBURSEMENT	B	-192,433	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	33.01
33.02	MISCELLANEOUS INCOME	B	0	TRAUMA INTENSIVE CARE UNIT	34.02	0	33.02
33.03	COUNTY ADJ FOR HOSPITAL BOND INT.	A	36,408,479	CAP REL COSTS-BLDG & FIXT	1.00	11	33.03
33.04	COUNTY ADJ FOR HOSPITAL BOND INT.	A	10,164,713	CAP REL COSTS-MVBLE EQUIP	2.00	11	33.04
33.05	COUNTY ADJ FOR HOSPITAL BOND INT.	A	8,971,683	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	RESERVE FOR CLAIMS	A	69,018	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.06
33.07	CRNA COSTS	A	-2,216,949	ANESTHESIOLOGY	53.00	0	33.07
33.08	IHA LOBBYING	A	-184,956	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	NON-PHYSICIAN PART B	A	-282,682	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.09
33.10	NON-PHYSICIAN PART B	A	-297,146	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	NON-PHYSICIAN PART B	A	-1,519,857	ADULTS & PEDIATRICS	30.00	0	33.11
33.12	NON-PHYSICIAN PART B	A	-128,376	SURGICAL INTENSIVE CARE UNIT	34.00	0	33.12
33.13	NON-PHYSICIAN PART B	A	-222,366	NEONATAL INTENSIVE CARE UNIT	34.04	0	33.13
33.14	NON-PHYSICIAN PART B	A	-650,507	OPERATING ROOM	50.00	0	33.14
33.15	NON-PHYSICIAN PART B	A	-279,881	DELIVERY ROOM & LABOR ROOM	52.00	0	33.15
33.16	NON-PHYSICIAN PART B	A	-244,495	LABORATORY	60.00	0	33.16
33.17	NON-PHYSICIAN PART B	A	-281,488	RENAL DIALYSIS	74.00	0	33.17
33.18	NON-PHYSICIAN PART B	A	-6,536,311	CLINIC	90.00	0	33.18
33.19	NON-PHYSICIAN PART B	A	-1,117,317	EMERGENCY	91.00	0	33.19
33.20	OAK FOREST VACANT SPACE	A	-447,276	CAP REL COSTS-BLDG & FIXT	1.00	9	33.20
33.21	PENSION ADJUSTMENT	A	138,393,895	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.21
33.22	NON-PHYSICIAN PART B	A	0	RENAL DIALYSIS	74.00	0	33.22
33.23	ADDITIONAL INTEREST	A	0	ADMINISTRATIVE & GENERAL	5.00	0	33.23
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		112,995,516				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021

Worksheet A-8-1

Date/Time Prepared:
5/2/2022 12:01 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	SYSTEM HEALTH & HOSPITAL - H	10,556,114	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	SYSTEM HEALTH & HOSPITAL - C	2,543,995	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	SYSTEM HEALTH & HOSPITAL - A	44,566,113	0	3.00
3.01	13.00	NURSING ADMINISTRATION	SYSTEM HEALTH & HOSPITAL - N	937,541	0	3.01
3.02	73.00	DRUGS CHARGED TO PATIENTS	SYSTEM HEALTH & HOSPITAL - P	658,036	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.			59,261,799	0	5.00

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

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

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

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

6.00	G	COOK COUNTY HEALTH & HOSPITAL	100.00	COOK COUNTY HEALTH & HOSPITAL SYSTEM	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021

Worksheet A-8-1

Date/Time Prepared:
5/2/2022 12:01 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	10,556,114	0		1.00
2.00	2,543,995	0		2.00
3.00	44,566,113	0		3.00
3.01	937,541	0		3.01
3.02	658,036	0		3.02
4.00	0	0		4.00
5.00	59,261,799			5.00

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

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

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

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

6.00	GOVERNMENT		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021

Worksheet A-8-2

Date/Time Prepared:
5/2/2022 12:01 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	595,401	386,910	208,490	211,500	1,577	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	475,014	45,784	429,230	211,500	1,853	2.00
3.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	10,435,369	52,249	10,383,120	211,500	68,567	3.00
4.00	30.00	ADULTS & PEDIATRICS	21,431,366	15,168,902	6,262,463	179,000	47,189	4.00
5.00	34.00	SURGICAL INTENSIVE CARE UNIT	860,442	634,689	225,753	179,000	1,407	5.00
6.00	34.02	TRAUMA INTENSIVE CARE UNIT	2,515,249	2,191,617	323,631	179,000	1,693	6.00
7.00	34.04	NEONATAL INTENSIVE CARE UNIT	185,224	185,224	0	0	0	7.00
8.00	50.00	OPERATING ROOM	11,530,094	10,834,802	695,292	246,400	4,099	8.00
9.00	51.00	RECOVERY ROOM	345,108	345,108	0	0	0	9.00
10.00	53.00	ANESTHESIOLOGY	7,396,775	7,082,774	314,001	239,400	1,423	10.00
11.00	54.00	RADIOLOGY-DIAGNOSTIC	9,064,739	7,662,101	1,402,638	271,900	6,369	11.00
12.00	60.00	LABORATORY	3,515,413	3,043,733	471,680	260,300	2,638	12.00
13.00	65.00	RESPIRATORY THERAPY	477,591	348,777	128,814	211,500	1,025	13.00
14.00	69.00	ELECTROCARDIOLOGY	324,395	324,395	0	211,500	0	14.00
15.00	74.00	RENAL DIALYSIS	2,393,365	2,263,029	130,336	211,500	861	15.00
16.00	90.00	CLINIC	57,375,018	46,395,473	10,979,545	179,000	78,796	16.00
17.00	91.00	EMERGENCY	8,988,102	6,851,584	2,136,518	246,400	12,750	17.00
200.00			137,908,665	103,817,151	34,091,511		230,247	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	160,354	8,018	0	0	75,253	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	188,418	9,421	0	0	60,037	2.00
3.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	6,972,077	348,604	0	0	76,249	3.00
4.00	30.00	ADULTS & PEDIATRICS	4,060,976	203,049	0	0	2,922,656	4.00
5.00	34.00	SURGICAL INTENSIVE CARE UNIT	121,083	6,054	0	0	123,721	5.00
6.00	34.02	TRAUMA INTENSIVE CARE UNIT	145,696	7,285	0	0	348,757	6.00
7.00	34.04	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	23,411	7.00
8.00	50.00	OPERATING ROOM	485,574	24,279	0	0	1,497,308	8.00
9.00	51.00	RECOVERY ROOM	0	0	0	0	47,733	9.00
10.00	53.00	ANESTHESIOLOGY	163,782	8,189	0	0	1,091,189	10.00
11.00	54.00	RADIOLOGY-DIAGNOSTIC	832,563	41,628	0	0	1,231,973	11.00
12.00	60.00	LABORATORY	330,130	16,507	0	0	454,952	12.00
13.00	65.00	RESPIRATORY THERAPY	104,225	5,211	0	0	60,363	13.00
14.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	41,001	14.00
15.00	74.00	RENAL DIALYSIS	87,549	4,377	0	0	310,837	15.00
16.00	90.00	CLINIC	6,781,002	339,050	0	0	7,754,948	16.00
17.00	91.00	EMERGENCY	1,510,385	75,519	0	0	1,310,019	17.00
200.00			21,943,814	1,097,191	0	0	17,430,407	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	26,351	186,705	21,785	408,696		1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	54,250	242,668	186,562	232,346		2.00
3.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	75,867	7,047,944	3,335,176	3,387,425		3.00
4.00	30.00	ADULTS & PEDIATRICS	854,030	4,915,006	1,347,457	16,516,360		4.00
5.00	34.00	SURGICAL INTENSIVE CARE UNIT	32,461	153,544	72,209	706,898		5.00
6.00	34.02	TRAUMA INTENSIVE CARE UNIT	44,874	190,570	133,061	2,324,679		6.00
7.00	34.04	NEONATAL INTENSIVE CARE UNIT	0	0	0	185,224		7.00
8.00	50.00	OPERATING ROOM	90,291	575,865	119,427	10,954,229		8.00
9.00	51.00	RECOVERY ROOM	0	0	0	345,108		9.00
10.00	53.00	ANESTHESIOLOGY	46,322	210,104	103,897	7,186,671		10.00
11.00	54.00	RADIOLOGY-DIAGNOSTIC	190,630	1,023,193	379,445	8,041,546		11.00
12.00	60.00	LABORATORY	61,043	391,173	80,507	3,124,240		12.00
13.00	65.00	RESPIRATORY THERAPY	16,281	120,506	8,308	357,085		13.00
14.00	69.00	ELECTROCARDIOLOGY	0	0	0	324,395		14.00
15.00	74.00	RENAL DIALYSIS	16,927	104,476	25,860	2,288,889		15.00
16.00	90.00	CLINIC	1,484,022	8,265,024	2,714,521	49,109,994		16.00
17.00	91.00	EMERGENCY	311,398	1,821,783	314,735	7,166,319		17.00
200.00			3,304,747	25,248,561	8,842,950	112,660,104		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet B
Part I
Date/Time Prepared:
5/2/2022 12:01 pm

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	51,755,049	51,755,049				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	18,210,046		18,210,046			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	239,024,775	415,911	0	239,440,686		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	226,091,809	7,741,828	14,860,245	15,580,456	264,274,338	5.00
7.00	00700	OPERATION OF PLANT	33,937,957	18,484,663	14,641	7,064,950	59,502,211	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,143,179	381,085	0	0	1,524,264	8.00
9.00	00900	HOUSEKEEPING	10,060,454	408,237	0	3,696,336	14,165,027	9.00
10.00	01000	DIETARY	1,310,082	21,891	0	340,388	1,672,361	10.00
11.00	01100	CAFETERIA	6,200,903	914,647	0	1,611,129	8,726,679	11.00
13.00	01300	NURSING ADMINISTRATION	10,279,319	249,020	30,457	2,887,759	13,446,555	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14,870,082	1,441,753	1,563,815	2,157,007	20,032,657	14.00
15.00	01500	PHARMACY	26,591,818	0	0	10,930,752	37,522,570	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,079,156	653,692	0	2,221,417	10,954,265	16.00
17.00	01700	SOCIAL SERVICE	0	78,652	0	0	78,652	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	29,471,370	22,587	0	14,640,371	44,134,328	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	8,375,938	0	0	6,535,162	14,911,100	22.00
23.00	02300	ALLIED HEALTH	210,920	2,717	0	115,364	329,001	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	39,162,661	6,002,164	0	30,020,777	75,185,602	30.00
31.00	03100	INTENSIVE CARE UNIT	6,719,743	609,801	0	3,675,417	11,004,961	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	3,163,423	130,173	0	1,730,260	5,023,856	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	2,914,547	205,108	0	2,050,995	5,170,650	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	4,368,429	493,128	0	3,412,114	8,273,671	34.02
34.03	02400	NEURO INTENSIVE CARE	2,005,699	103,043	0	1,097,033	3,205,775	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	4,384,984	262,759	0	2,621,337	7,269,080	34.04
43.00	04300	NURSERY	2,314,861	187,977	0	1,266,132	3,768,970	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	29,454,630	1,504,579	0	13,761,238	44,720,447	50.00
51.00	05100	RECOVERY ROOM	2,926,328	290,325	0	1,789,338	5,005,991	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,235,826	287,651	0	1,922,944	5,446,421	52.00
53.00	05300	ANESTHESIOLOGY	1,445,366	100,326	0	5,662,356	7,208,048	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,706,529	2,042,402	1,012	10,865,905	36,615,848	54.00
60.00	06000	LABORATORY	26,209,793	1,672,382	0	6,340,416	34,222,591	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	3,155,720	59,956	0	471,077	3,686,753	62.00
65.00	06500	RESPIRATORY THERAPY	4,619,831	119,738	35,641	1,705,872	6,481,082	65.00
66.00	06600	PHYSICAL THERAPY	3,173,585	100,217	0	1,605,656	4,879,458	66.00
67.00	06700	OCCUPATIONAL THERAPY	991,309	96,391	0	501,556	1,589,256	67.00
68.00	06800	SPEECH PATHOLOGY	785,474	49,695	0	287,366	1,122,535	68.00
69.00	06900	ELECTROCARDIOLOGY	5,896,747	462,150	0	1,369,090	7,727,987	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,177,693	0	0	0	13,177,693	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,602,153	0	0	0	6,602,153	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	79,915,191	249,629	1,484,206	0	81,649,026	73.00
74.00	07400	RENAL DIALYSIS	1,824,450	50,565	0	2,313,439	4,188,454	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	67,199,069	4,099,456	220,029	60,083,325	131,601,879	90.00
91.00	09100	EMERGENCY	20,679,196	1,568,513	0	15,834,138	38,081,847	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,045,646,094	51,564,811	18,210,046	238,168,872	1,044,184,042	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	2,325,249	134,282	0	1,271,814	3,731,345	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	0	55,956	0	0	55,956	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,047,971,343	51,755,049	18,210,046	239,440,686	1,047,971,343	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet B
Part I
Date/Time Prepared:
5/2/2022 12:01 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	264,274,338					5.00
7.00	00700	OPERATION OF PLANT	20,065,038	79,567,249				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	514,005	1,207,435	3,245,704			8.00
9.00	00900	HOUSEKEEPING	4,776,660	1,293,463	0	20,235,150		9.00
10.00	01000	DIETARY	563,945	69,360	0	18,212	2,323,878	10.00
11.00	01100	CAFETERIA	2,942,767	2,897,981	0	760,917	0	11.00
13.00	01300	NURSING ADMINISTRATION	4,534,380	789,000	0	207,166	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,755,312	4,568,070	0	1,199,429	0	14.00
15.00	01500	PHARMACY	12,653,173	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,693,942	2,071,167	0	543,822	0	16.00
17.00	01700	SOCIAL SERVICE	26,523	249,201	0	65,432	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	14,882,757	71,564	0	18,791	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	5,028,247	0	0	0	0	22.00
23.00	02300	ALLIED HEALTH	110,944	8,610	0	2,261	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	25,353,713	19,017,331	889,625	4,993,340	1,034,322	30.00
31.00	03100	INTENSIVE CARE UNIT	3,711,038	1,932,102	131,063	507,308	78,211	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	1,694,120	412,443	99,369	108,294	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,743,621	649,866	134,247	170,634	30,710	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	2,790,006	1,562,433	148,472	410,245	0	34.02
34.03	02400	NEURO INTENSIVE CARE	1,081,035	326,483	12,386	85,724	13,785	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	2,451,243	832,531	117,884	218,596	0	34.04
43.00	04300	NURSERY	1,270,953	595,590	41,388	156,383	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	15,080,406	4,767,128	451,637	1,251,695	14,667	50.00
51.00	05100	RECOVERY ROOM	1,688,095	919,868	143,772	241,528	27,421	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,836,615	911,396	177,556	239,303	19,930	52.00
53.00	05300	ANESTHESIOLOGY	2,430,662	317,873	22,937	83,463	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,347,413	6,471,174	331,664	1,699,123	32,639	54.00
60.00	06000	LABORATORY	11,540,371	5,298,799	0	1,391,294	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,243,228	189,966	0	49,879	0	62.00
65.00	06500	RESPIRATORY THERAPY	2,185,518	379,381	0	99,613	0	65.00
66.00	06600	PHYSICAL THERAPY	1,645,426	317,528	26,093	83,373	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	535,921	305,406	0	80,190	0	67.00
68.00	06800	SPEECH PATHOLOGY	378,536	157,456	0	41,343	3,185	68.00
69.00	06900	ELECTROCARDIOLOGY	2,605,993	1,464,281	35,962	384,473	22,307	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,443,716	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,226,345	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,533,276	790,928	0	207,672	0	73.00
74.00	07400	RENAL DIALYSIS	1,412,410	160,211	0	42,066	6,623	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	44,378,080	12,988,772	21,415	3,410,435	308,656	90.00
91.00	09100	EMERGENCY	12,841,770	4,969,699	460,234	1,304,883	731,422	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	262,997,203	78,964,496	3,245,704	20,076,887	2,323,878	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	1,258,266	425,461	0	111,712	0	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	18,869	177,292	0	46,551	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	264,274,338	79,567,249	3,245,704	20,235,150	2,323,878	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet B
Part I
Date/Time Prepared:
5/2/2022 12:01 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			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
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	15,328,344					11.00
13.00	01300	NURSING ADMINISTRATION	203,501	19,180,602				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	307,765	0	32,863,233			14.00
15.00	01500	PHARMACY	882,048	0	0	51,057,791		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	241,292	0	0	0	17,504,488	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,809,258	0	383	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	211,742	0	4,607	0	0	22.00
23.00	02300	ALLIED HEALTH	18,886	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,102,240	5,055,611	17,080	0	2,127,169	30.00
31.00	03100	INTENSIVE CARE UNIT	321,534	1,425,389	0	0	358,816	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	133,478	538,576	0	0	68,743	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	132,826	487,297	0	0	118,779	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	212,235	514,798	2,040	0	130,746	34.02
34.03	02400	NEURO INTENSIVE CARE	94,294	376,468	0	0	96,222	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	193,072	856,628	0	0	151,306	34.04
43.00	04300	NURSERY	106,383	379,381	0	0	89,954	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	757,858	1,951,111	9,011,640	0	2,417,443	50.00
51.00	05100	RECOVERY ROOM	135,902	559,038	0	0	227,404	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	160,461	642,346	0	0	34,670	52.00
53.00	05300	ANESTHESIOLOGY	172,258	0	264,883	0	842,673	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	682,668	550,580	1,053,826	0	2,013,156	54.00
60.00	06000	LABORATORY	598,066	0	6,534,378	0	2,025,863	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	41,446	0	1,497,297	0	178,468	62.00
65.00	06500	RESPIRATORY THERAPY	184,802	0	340,171	0	205,046	65.00
66.00	06600	PHYSICAL THERAPY	137,698	0	39,582	0	93,536	66.00
67.00	06700	OCCUPATIONAL THERAPY	48,359	0	3,407	0	31,730	67.00
68.00	06800	SPEECH PATHOLOGY	23,239	0	244	0	21,253	68.00
69.00	06900	ELECTROCARDIOLOGY	107,805	80,307	1,690,726	0	565,876	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	11,831,201	0	240,462	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	266,783	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	59,311	51,057,791	2,910,429	73.00
74.00	07400	RENAL DIALYSIS	122,535	177,703	19,106	0	173,149	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	4,110,573	2,659,118	485,509	0	1,382,018	90.00
91.00	09100	EMERGENCY	1,056,568	2,926,251	7,842	0	732,794	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,310,792	19,180,602	32,863,233	51,057,791	17,504,488	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	17,552	0	0	0	0	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	15,328,344	19,180,602	32,863,233	51,057,791	17,504,488	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet B
Part I
Date/Time Prepared:
5/2/2022 12:01 pm

Cost Center Description			INTERNS & RESIDENTS		ALLIED HEALTH	Subtotal	
			SOCIAL SERVICE	SERVICES-SALAR	SERVICES-OTHER		
				Y & FRINGES APPRV	PRGM COSTS APPRV		
			17.00	21.00	22.00	23.00	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
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	419,808				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	60,917,081			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		20,155,696		22.00
23.00	02300	ALLIED HEALTH	0			469,702	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	30,161,081	9,979,426	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	0	0	0	0	34.02
34.03	02400	NEURO INTENSIVE CARE	0	0	0	0	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	34.04
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	6,067,578	2,007,586	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	5,749,633	1,902,387	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,514,595	832,007	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	145,092	48,007	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	469,702	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	405,758	6,346,813	2,099,976	0	90.00
91.00	09100	EMERGENCY	14,050	9,932,289	3,286,307	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	419,808	60,917,081	20,155,696	469,702	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	0	0	0	0	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	190.04
194.00	07950	COUNTYCARE	0	0	0	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	419,808	60,917,081	20,155,696	469,702	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet B
Part I
Date/Time Prepared:
5/2/2022 12:01 pm

Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
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 APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
23.00	02300	ALLIED HEALTH			23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-40,140,507	135,776,033	30.00
31.00	03100	INTENSIVE CARE UNIT	0	19,470,422	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	8,078,879	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	8,638,630	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	0	14,044,646	34.02
34.03	02400	NEURO INTENSIVE CARE	0	5,292,172	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	0	12,090,340	34.04
43.00	04300	NURSERY	0	6,409,002	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-8,075,164	80,424,032	50.00
51.00	05100	RECOVERY ROOM	0	8,949,019	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	9,468,698	52.00
53.00	05300	ANESTHESIOLOGY	-7,652,020	11,342,797	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-3,346,602	61,798,091	54.00
60.00	06000	LABORATORY	0	61,611,362	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	6,887,037	62.00
65.00	06500	RESPIRATORY THERAPY	0	9,875,613	65.00
66.00	06600	PHYSICAL THERAPY	0	7,222,694	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,594,269	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,747,791	68.00
69.00	06900	ELECTROCARDIOLOGY	-193,099	14,685,717	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	29,693,072	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,095,281	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	164,678,135	73.00
74.00	07400	RENAL DIALYSIS	0	6,302,257	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-8,446,789	201,752,213	90.00
91.00	09100	EMERGENCY	-13,218,596	63,127,360	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-81,072,777	961,055,562	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	190.00
190.03	19003	SPECIAL FUNDS	0	5,544,336	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	190.04
194.00	07950	COUNTYCARE	0	298,668	194.00
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)	-81,072,777	966,898,566	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet B
Part II
Date/Time Prepared:
5/2/2022 12:01 pm

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	415,911	0	415,911	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	28,438,500	7,741,828	14,860,245	51,040,573	5.00
7.00	00700	OPERATION OF PLANT	0	18,484,663	14,641	18,499,304	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	381,085	0	381,085	8.00
9.00	00900	HOUSEKEEPING	0	408,237	0	408,237	9.00
10.00	01000	DIETARY	0	21,891	0	21,891	10.00
11.00	01100	CAFETERIA	0	914,647	0	914,647	11.00
13.00	01300	NURSING ADMINISTRATION	0	249,020	30,457	279,477	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	535,856	1,441,753	1,563,815	3,541,424	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	653,692	0	653,692	16.00
17.00	01700	SOCIAL SERVICE	0	78,652	0	78,652	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	22,587	0	22,587	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	ALLIED HEALTH	0	2,717	0	2,717	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	6,002,164	0	6,002,164	30.00
31.00	03100	INTENSIVE CARE UNIT	0	609,801	0	609,801	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	130,173	0	130,173	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	205,108	0	205,108	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	0	493,128	0	493,128	34.02
34.03	02400	NEURO INTENSIVE CARE	0	103,043	0	103,043	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	0	262,759	0	262,759	34.04
43.00	04300	NURSERY	0	187,977	0	187,977	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,504,579	0	1,504,579	50.00
51.00	05100	RECOVERY ROOM	0	290,325	0	290,325	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	287,651	0	287,651	52.00
53.00	05300	ANESTHESIOLOGY	0	100,326	0	100,326	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	328,199	2,042,402	1,012	2,371,613	54.00
60.00	06000	LABORATORY	0	1,672,382	0	1,672,382	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	59,956	0	59,956	62.00
65.00	06500	RESPIRATORY THERAPY	475,831	119,738	35,641	631,210	65.00
66.00	06600	PHYSICAL THERAPY	0	100,217	0	100,217	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	96,391	0	96,391	67.00
68.00	06800	SPEECH PATHOLOGY	0	49,695	0	49,695	68.00
69.00	06900	ELECTROCARDIOLOGY	0	462,150	0	462,150	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,599,293	249,629	1,484,206	3,333,128	73.00
74.00	07400	RENAL DIALYSIS	0	50,565	0	50,565	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,270,729	4,099,456	220,029	5,590,214	90.00
91.00	09100	EMERGENCY	0	1,568,513	0	1,568,513	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,648,408	51,564,811	18,210,046	102,423,265	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	0	134,282	0	134,282	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	190.04
194.00	07950	COUNTYCARE	0	55,956	0	55,956	194.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	32,648,408	51,755,049	18,210,046	102,613,503	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet B
Part II
Date/Time Prepared:
5/2/2022 12:01 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	51,067,634					5.00
7.00	00700	OPERATION OF PLANT	3,877,283	22,388,858				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	99,324	339,751	820,160			8.00
9.00	00900	HOUSEKEEPING	923,021	363,958	0	1,701,636		9.00
10.00	01000	DIETARY	108,974	19,517	0	1,531	152,504	10.00
11.00	01100	CAFETERIA	568,648	815,442	0	63,988	0	11.00
13.00	01300	NURSING ADMINISTRATION	876,204	222,011	0	17,421	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,305,368	1,285,376	0	100,864	0	14.00
15.00	01500	PHARMACY	2,445,046	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	713,802	582,791	0	45,732	0	16.00
17.00	01700	SOCIAL SERVICE	5,125	70,121	0	5,502	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	2,875,881	20,137	0	1,580	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	971,637	0	0	0	0	22.00
23.00	02300	ALLIED HEALTH	21,438	2,423	0	190	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,899,244	5,351,152	224,798	419,905	67,876	30.00
31.00	03100	INTENSIVE CARE UNIT	717,105	543,660	33,119	42,661	5,133	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	327,365	116,054	25,110	9,107	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	336,930	182,861	33,923	14,349	2,015	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	539,129	439,642	37,518	34,499	0	34.02
34.03	02400	NEURO INTENSIVE CARE	208,895	91,867	3,130	7,209	905	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	473,668	234,260	29,788	18,382	0	34.04
43.00	04300	NURSERY	245,594	167,589	10,458	13,151	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,914,074	1,341,388	114,125	105,259	963	50.00
51.00	05100	RECOVERY ROOM	326,200	258,835	36,330	20,311	1,799	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	354,900	256,451	44,867	20,124	1,308	52.00
53.00	05300	ANESTHESIOLOGY	469,691	89,444	5,796	7,019	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,385,962	1,820,877	83,809	142,884	2,142	54.00
60.00	06000	LABORATORY	2,230,012	1,490,991	0	116,998	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	240,236	53,453	0	4,194	0	62.00
65.00	06500	RESPIRATORY THERAPY	422,320	106,751	0	8,377	0	65.00
66.00	06600	PHYSICAL THERAPY	317,955	89,347	6,594	7,011	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	103,559	85,936	0	6,743	0	67.00
68.00	06800	SPEECH PATHOLOGY	73,147	44,305	0	3,477	209	68.00
69.00	06900	ELECTROCARDIOLOGY	503,571	412,024	9,087	32,332	1,464	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	858,685	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	430,209	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,320,414	222,554	0	17,464	0	73.00
74.00	07400	RENAL DIALYSIS	272,928	45,081	0	3,537	435	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	8,575,813	3,654,817	5,411	286,794	20,256	90.00
91.00	09100	EMERGENCY	2,481,489	1,398,388	116,297	109,732	47,999	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	50,820,846	22,219,254	820,160	1,688,327	152,504	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	243,142	119,717	0	9,394	0	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	3,646	49,887	0	3,915	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	51,067,634	22,388,858	820,160	1,701,636	152,504	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet B
Part II
Date/Time Prepared:
5/2/2022 12:01 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			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
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	2,365,523					11.00
13.00	01300	NURSING ADMINISTRATION	31,405	1,431,534				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	47,495	0	6,284,273			14.00
15.00	01500	PHARMACY	136,121	0	0	2,600,152		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	37,237	0	0	0	2,037,112	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	279,211	0	73	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	32,677	0	881	0	0	22.00
23.00	02300	ALLIED HEALTH	2,915	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	324,425	377,324	3,266	0	247,589	30.00
31.00	03100	INTENSIVE CARE UNIT	49,620	106,383	0	0	41,764	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	20,599	40,196	0	0	8,001	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	20,498	36,369	0	0	13,825	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	32,753	38,422	390	0	15,218	34.02
34.03	02400	NEURO INTENSIVE CARE	14,552	28,097	0	0	11,200	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	29,795	63,934	0	0	17,611	34.04
43.00	04300	NURSERY	16,417	28,315	0	0	10,470	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	116,955	145,620	1,723,254	0	281,375	50.00
51.00	05100	RECOVERY ROOM	20,973	41,723	0	0	26,468	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	24,763	47,941	0	0	4,035	52.00
53.00	05300	ANESTHESIOLOGY	26,583	0	50,652	0	98,082	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	105,352	41,092	201,518	0	234,318	54.00
60.00	06000	LABORATORY	92,296	0	1,249,539	0	235,797	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	6,396	0	286,321	0	20,773	62.00
65.00	06500	RESPIRATORY THERAPY	28,519	0	65,049	0	23,866	65.00
66.00	06600	PHYSICAL THERAPY	21,250	0	7,569	0	10,887	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,463	0	651	0	3,693	67.00
68.00	06800	SPEECH PATHOLOGY	3,586	0	47	0	2,474	68.00
69.00	06900	ELECTROCARDIOLOGY	16,637	5,994	323,310	0	65,864	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	2,262,415	0	27,988	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	31,052	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	11,342	2,600,152	338,459	73.00
74.00	07400	RENAL DIALYSIS	18,910	13,263	3,654	0	20,153	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	634,358	198,462	92,842	0	160,858	90.00
91.00	09100	EMERGENCY	163,053	218,399	1,500	0	85,292	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,362,814	1,431,534	6,284,273	2,600,152	2,037,112	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	2,709	0	0	0	0	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,365,523	1,431,534	6,284,273	2,600,152	2,037,112	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet B
Part II
Date/Time Prepared:
5/2/2022 12:01 pm

Cost Center Description			INTERNS & RESIDENTS		ALLIED HEALTH	Subtotal	
			SOCIAL SERVICE	SERVICES-SALAR	SERVICES-OTHER		
				Y & FRINGES APPRV	PRGM COSTS APPRV		
			17.00	21.00	22.00	23.00	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
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	159,400				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	3,224,898			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		1,016,546		22.00
23.00	02300	ALLIED HEALTH	0			29,883	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0			17,969,885	30.00
31.00	03100	INTENSIVE CARE UNIT	0			2,155,630	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0			679,610	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0			849,440	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0			0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	0			1,636,625	34.02
34.03	02400	NEURO INTENSIVE CARE	0			470,803	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	0			1,134,750	34.04
43.00	04300	NURSERY	0			682,170	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0			8,271,494	50.00
51.00	05100	RECOVERY ROOM	0			1,026,072	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0			1,045,380	52.00
53.00	05300	ANESTHESIOLOGY	0			857,428	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0			7,408,440	54.00
60.00	06000	LABORATORY	0			7,099,028	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0			672,147	62.00
65.00	06500	RESPIRATORY THERAPY	0			1,289,055	65.00
66.00	06600	PHYSICAL THERAPY	0			563,619	66.00
67.00	06700	OCCUPATIONAL THERAPY	0			305,307	67.00
68.00	06800	SPEECH PATHOLOGY	0			177,439	68.00
69.00	06900	ELECTROCARDIOLOGY	0			1,834,811	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0			3,149,088	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0			461,261	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0			11,843,513	73.00
74.00	07400	RENAL DIALYSIS	0			432,544	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	154,065			19,478,281	90.00
91.00	09100	EMERGENCY	5,335			6,223,499	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	159,400	0	0	0	97,717,319
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0				190.00
190.03	19003	SPECIAL FUNDS	0			511,453	190.03
190.04	19004	SENGSTACKE CLINIC	0			0	190.04
194.00	07950	COUNTYCARE	0			113,404	194.00
200.00		Cross Foot Adjustments		3,224,898	1,016,546	29,883	4,271,327
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	159,400	3,224,898	1,016,546	29,883	102,613,503

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet B
Part II
Date/Time Prepared:
5/2/2022 12:01 pm

Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
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 APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
23.00	02300	ALLIED HEALTH			23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	17,969,885	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,155,630	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	679,610	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	849,440	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	0	1,636,625	34.02
34.03	02400	NEURO INTENSIVE CARE	0	470,803	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	0	1,134,750	34.04
43.00	04300	NURSERY	0	682,170	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	8,271,494	50.00
51.00	05100	RECOVERY ROOM	0	1,026,072	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,045,380	52.00
53.00	05300	ANESTHESIOLOGY	0	857,428	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,408,440	54.00
60.00	06000	LABORATORY	0	7,099,028	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	672,147	62.00
65.00	06500	RESPIRATORY THERAPY	0	1,289,055	65.00
66.00	06600	PHYSICAL THERAPY	0	563,619	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	305,307	67.00
68.00	06800	SPEECH PATHOLOGY	0	177,439	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,834,811	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,149,088	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	461,261	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,843,513	73.00
74.00	07400	RENAL DIALYSIS	0	432,544	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	19,478,281	90.00
91.00	09100	EMERGENCY	0	6,223,499	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	97,717,319	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	190.00
190.03	19003	SPECIAL FUNDS	0	511,453	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	190.04
194.00	07950	COUNTYCARE	0	113,404	194.00
200.00		Cross Foot Adjustments	0	4,271,327	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	102,613,503	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021

Worksheet B-1

Date/Time Prepared:
5/2/2022 12:01 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,380,745					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		28,065,353				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	19,132	0	437,767,711			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	356,126	22,902,632	28,485,654	-264,274,338	783,697,005	5.00
7.00	00700	OPERATION OF PLANT	850,299	22,565	12,916,806	0	59,502,211	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,530	0	0	0	1,524,264	8.00
9.00	00900	HOUSEKEEPING	18,779	0	6,757,988	0	14,165,027	9.00
10.00	01000	DIETARY	1,007	0	622,329	0	1,672,361	10.00
11.00	01100	CAFETERIA	42,074	0	2,945,618	0	8,726,679	11.00
13.00	01300	NURSING ADMINISTRATION	11,455	46,940	5,279,672	0	13,446,555	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	66,321	2,410,155	3,943,642	0	20,032,657	14.00
15.00	01500	PHARMACY	0	0	19,984,627	0	37,522,570	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	30,070	0	4,061,403	0	10,954,265	16.00
17.00	01700	SOCIAL SERVICE	3,618	0	0	0	78,652	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,039	0	26,766,902	0	44,134,328	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	11,948,198	0	14,911,100	22.00
23.00	02300	ALLIED HEALTH	125	0	210,920	0	329,001	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	276,101	0	54,886,804	0	75,185,602	30.00
31.00	03100	INTENSIVE CARE UNIT	28,051	0	6,719,743	0	11,004,961	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	5,988	0	3,163,423	0	5,023,856	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	9,435	0	3,749,821	0	5,170,650	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	22,684	0	6,238,347	0	8,273,671	34.02
34.03	02400	NEURO INTENSIVE CARE	4,740	0	2,005,699	0	3,205,775	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	12,087	0	4,792,574	0	7,269,080	34.04
43.00	04300	NURSERY	8,647	0	2,314,861	0	3,768,970	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	69,211	0	25,159,588	0	44,720,447	50.00
51.00	05100	RECOVERY ROOM	13,355	0	3,271,436	0	5,005,991	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,232	0	3,515,707	0	5,446,421	52.00
53.00	05300	ANESTHESIOLOGY	4,615	0	10,352,451	0	7,208,048	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	93,951	1,560	19,866,069	0	36,615,848	54.00
60.00	06000	LABORATORY	76,930	0	11,592,145	0	34,222,591	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,758	0	861,267	0	3,686,753	62.00
65.00	06500	RESPIRATORY THERAPY	5,508	54,930	3,118,835	0	6,481,082	65.00
66.00	06600	PHYSICAL THERAPY	4,610	0	2,935,611	0	4,879,458	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,434	0	916,992	0	1,589,256	67.00
68.00	06800	SPEECH PATHOLOGY	2,286	0	525,390	0	1,122,535	68.00
69.00	06900	ELECTROCARDIOLOGY	21,259	0	2,503,099	0	7,727,987	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	13,177,693	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	6,602,153	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,483	2,287,462	0	0	81,649,026	73.00
74.00	07400	RENAL DIALYSIS	2,326	0	4,229,647	0	4,188,454	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	188,576	339,109	109,849,736	0	131,601,879	90.00
91.00	09100	EMERGENCY	72,152	0	28,949,458	0	38,081,847	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,371,994	28,065,353	435,442,462	-264,274,338	779,909,704	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	6,177	0	2,325,249	0	3,731,345	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	2,574	0	0	0	55,956	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	51,755,049	18,210,046	239,440,686		264,274,338	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.739014	0.648844	0.546958		0.337215	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			415,911		51,067,634	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000950		0.065162	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021

Worksheet B-1

Date/Time Prepared:
5/2/2022 12:01 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021

Worksheet B-1

Date/Time Prepared:
5/2/2022 12:01 pm

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
			7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	1,155,188					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,530	2,232,635				8.00
9.00	00900	HOUSEKEEPING	18,779	0	1,118,879			9.00
10.00	01000	DIETARY	1,007	0	1,007	155,429		10.00
11.00	01100	CAFETERIA	42,074	0	42,074	0	7,306,199	11.00
13.00	01300	NURSING ADMINISTRATION	11,455	0	11,455	0	96,998	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	66,321	0	66,321	0	146,695	14.00
15.00	01500	PHARMACY	0	0	0	0	420,425	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	30,070	0	30,070	0	115,011	16.00
17.00	01700	SOCIAL SERVICE	3,618	0	3,618	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,039	0	1,039	0	862,376	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	100,926	22.00
23.00	02300	ALLIED HEALTH	125	0	125	0	9,002	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	276,101	611,950	276,101	69,179	1,002,025	30.00
31.00	03100	INTENSIVE CARE UNIT	28,051	90,155	28,051	5,231	153,258	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	5,988	68,353	5,988	0	63,622	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	9,435	92,345	9,435	2,054	63,311	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	22,684	102,130	22,684	0	101,161	34.02
34.03	02400	NEURO INTENSIVE CARE	4,740	8,520	4,740	922	44,945	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	12,087	81,089	12,087	0	92,027	34.04
43.00	04300	NURSERY	8,647	28,470	8,647	0	50,707	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	69,211	310,669	69,211	981	361,230	50.00
51.00	05100	RECOVERY ROOM	13,355	98,897	13,355	1,834	64,777	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,232	122,136	13,232	1,333	76,483	52.00
53.00	05300	ANESTHESIOLOGY	4,615	15,778	4,615	0	82,106	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	93,951	228,143	93,951	2,183	325,391	54.00
60.00	06000	LABORATORY	76,930	0	76,930	0	285,066	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,758	0	2,758	0	19,755	62.00
65.00	06500	RESPIRATORY THERAPY	5,508	0	5,508	0	88,085	65.00
66.00	06600	PHYSICAL THERAPY	4,610	17,949	4,610	0	65,633	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,434	0	4,434	0	23,050	67.00
68.00	06800	SPEECH PATHOLOGY	2,286	0	2,286	213	11,077	68.00
69.00	06900	ELECTROCARDIOLOGY	21,259	24,737	21,259	1,492	51,385	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,483	0	11,483	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,326	0	2,326	443	58,406	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	188,576	14,731	188,576	20,644	1,959,291	90.00
91.00	09100	EMERGENCY	72,152	316,583	72,152	48,920	503,609	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,146,437	2,232,635	1,110,128	155,429	7,297,833	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	6,177	0	6,177	0	8,366	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	2,574	0	2,574	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	79,567,249	3,245,704	20,235,150	2,323,878	15,328,344	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	68.878182	1.453755	18.085200	14.951380	2.097992	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	22,388,858	820,160	1,701,636	152,504	2,365,523	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	19.381138	0.367351	1.520840	0.981181	0.323769	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021

Worksheet B-1

Date/Time Prepared:
5/2/2022 12:01 pm

Cost Center Description			NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	1,757,634					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	54,108,190				14.00
15.00	01500	PHARMACY	0	0	1,000			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,247,604,492		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	62,209	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	630	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	7,585	0	0	0	22.00
23.00	02300	ALLIED HEALTH	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	463,276	28,122	0	151,615,744	0	30.00
31.00	03100	INTENSIVE CARE UNIT	130,617	0	0	25,574,880	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	49,353	0	0	4,899,748	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	44,654	0	0	8,466,060	0	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	47,174	3,359	0	9,319,016	0	34.02
34.03	02400	NEURO INTENSIVE CARE	34,498	0	0	6,858,296	0	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	78,498	0	0	10,784,468	0	34.04
43.00	04300	NURSERY	34,765	0	0	6,411,554	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	178,792	14,837,345	0	172,305,307	0	50.00
51.00	05100	RECOVERY ROOM	51,228	0	0	16,208,400	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	58,862	0	0	2,471,167	0	52.00
53.00	05300	ANESTHESIOLOGY	0	436,120	0	60,062,218	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	50,453	1,735,087	0	143,489,412	0	54.00
60.00	06000	LABORATORY	0	10,758,622	0	144,395,058	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	2,465,246	0	12,720,467	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	560,079	0	14,614,848	0	65.00
66.00	06600	PHYSICAL THERAPY	0	65,171	0	6,666,841	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,609	0	2,261,600	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	402	0	1,514,832	0	68.00
69.00	06900	ELECTROCARDIOLOGY	7,359	2,783,720	0	40,333,293	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	19,479,697	0	17,139,139	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	19,015,159	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	97,653	1,000	207,400,663	0	73.00
74.00	07400	RENAL DIALYSIS	16,284	31,458	0	12,341,346	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	243,671	799,374	0	98,504,476	60,127	90.00
91.00	09100	EMERGENCY	268,150	12,911	0	52,230,500	2,082	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,757,634	54,108,190	1,000	1,247,604,492	62,209	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	0	0	0	0	0	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	19,180,602	32,863,233	51,057,791	17,504,488	419,808	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.912740	0.607362	51,057.791000	0.014030	6.748348	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,431,534	6,284,273	2,600,152	2,037,112	159,400	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.814466	0.116143	2,600.152000	0.001633	2.562330	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet B-1
Date/Time Prepared:
5/2/2022 12:01 pm

Cost Center Description			INTERNS & RESIDENTS		ALLIED HEALTH (ASSIGNED TIME)	
			SERVICES-SALAR	SERVICES-OTHER		
			Y & FRINGES APPRV (ASSIGNED TIME)	PRGM COSTS APPRV (ASSIGNED TIME)		
			21.00	22.00	23.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
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 APPRV	862,376			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		862,376		22.00
23.00	02300	ALLIED HEALTH			1,000	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	426,977	426,977	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	0	0	0	34.02
34.03	02400	NEURO INTENSIVE CARE	0	0	0	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	34.04
43.00	04300	NURSERY	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	85,896	85,896	0	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	81,395	81,395	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,598	35,598	0	54.00
60.00	06000	LABORATORY	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,054	2,054	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	89,849	89,849	0	90.00
91.00	09100	EMERGENCY	140,607	140,607	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	862,376	862,376	1,000	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	0	0	0	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	190.04
194.00	07950	COUNTYCARE	0	0	0	194.00
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	60,917,081	20,155,696	469,702	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	70.638655	23.372283	469.702000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	3,224,898	1,016,546	29,883	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.739550	1.178774	29.883000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			0	206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021

Worksheet B-1

Date/Time Prepared:
5/2/2022 12:01 pm

Cost Center Description			INTERNS & RESIDENTS		ALLIED HEALTH (ASSIGNED TIME)		
			SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)			
			21.00	22.00	23.00		
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet C
Part I
Date/Time Prepared:
5/2/2022 12:01 pm

				Title XVIII		Hospital		PPS	
Cost Center Description				Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
						Total Costs	RCE Disallowance	Total Costs	
				1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	135,776,033		135,776,033	1,347,457	137,123,490	30.00	
31.00	03100	INTENSIVE CARE UNIT	19,470,422		19,470,422	0	19,470,422	31.00	
33.00	03300	BURN INTENSIVE CARE UNIT	8,078,879		8,078,879	0	8,078,879	33.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	8,638,630		8,638,630	72,209	8,710,839	34.00	
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0		0	0	0	34.01	
34.02	02180	TRAUMA INTENSIVE CARE UNIT	14,044,646		14,044,646	133,061	14,177,707	34.02	
34.03	02400	NEURO INTENSIVE CARE	5,292,172		5,292,172	0	5,292,172	34.03	
34.04	02060	NEONATAL INTENSIVE CARE UNIT	12,090,340		12,090,340	0	12,090,340	34.04	
43.00	04300	NURSERY	6,409,002		6,409,002	0	6,409,002	43.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	80,424,032		80,424,032	119,427	80,543,459	50.00	
51.00	05100	RECOVERY ROOM	8,949,019		8,949,019	0	8,949,019	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,468,698		9,468,698	0	9,468,698	52.00	
53.00	05300	ANESTHESIOLOGY	11,342,797		11,342,797	103,897	11,446,694	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	61,798,091		61,798,091	379,445	62,177,536	54.00	
60.00	06000	LABORATORY	61,611,362		61,611,362	80,507	61,691,869	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	6,887,037		6,887,037	0	6,887,037	62.00	
65.00	06500	RESPIRATORY THERAPY	9,875,613	0	9,875,613	8,308	9,883,921	65.00	
66.00	06600	PHYSICAL THERAPY	7,222,694	0	7,222,694	0	7,222,694	66.00	
67.00	06700	OCCUPATIONAL THERAPY	2,594,269	0	2,594,269	0	2,594,269	67.00	
68.00	06800	SPEECH PATHOLOGY	1,747,791	0	1,747,791	0	1,747,791	68.00	
69.00	06900	ELECTROCARDIOLOGY	14,685,717		14,685,717	0	14,685,717	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	29,693,072		29,693,072	0	29,693,072	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,095,281		9,095,281	0	9,095,281	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	164,678,135		164,678,135	0	164,678,135	73.00	
74.00	07400	RENAL DIALYSIS	6,302,257		6,302,257	25,860	6,328,117	74.00	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	201,752,213		201,752,213	2,714,521	204,466,734	90.00	
91.00	09100	EMERGENCY	63,127,360		63,127,360	314,735	63,442,095	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	23,577,656		23,577,656		23,577,656	92.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	984,633,218	0	984,633,218	5,299,427	989,932,645	200.00	
201.00		Less Observation Beds	23,577,656		23,577,656		23,577,656	201.00	
202.00		Total (see instructions)	961,055,562	0	961,055,562	5,299,427	966,354,989	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet C
Part I
Date/Time Prepared:
5/2/2022 12:01 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	124,166,100		124,166,100			30.00	
31.00	03100	INTENSIVE CARE UNIT	25,574,880		25,574,880			31.00	
33.00	03300	BURN INTENSIVE CARE UNIT	4,899,748		4,899,748			33.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	8,466,060		8,466,060			34.00	
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0		0			34.01	
34.02	02180	TRAUMA INTENSIVE CARE UNIT	9,319,016		9,319,016			34.02	
34.03	02400	NEURO INTENSIVE CARE	6,858,296		6,858,296			34.03	
34.04	02060	NEONATAL INTENSIVE CARE UNIT	10,784,468		10,784,468			34.04	
43.00	04300	NURSERY	6,411,554		6,411,554			43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	91,282,988	81,022,319	172,305,307	0.466753	0.000000	50.00	
51.00	05100	RECOVERY ROOM	5,409,500	10,798,900	16,208,400	0.552122	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,452,126	19,041	2,471,167	3.831671	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	36,007,994	24,054,224	60,062,218	0.188851	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,840,208	100,649,204	143,489,412	0.430680	0.000000	54.00	
60.00	06000	LABORATORY	46,730,867	97,664,191	144,395,058	0.426686	0.000000	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	8,740,329	3,980,138	12,720,467	0.541414	0.000000	62.00	
65.00	06500	RESPIRATORY THERAPY	12,264,771	2,350,077	14,614,848	0.675725	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	3,692,267	2,974,574	6,666,841	1.083376	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	1,325,840	935,760	2,261,600	1.147095	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	543,726	971,106	1,514,832	1.153785	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	21,921,489	18,411,804	40,333,293	0.364109	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,926,944	6,212,195	17,139,139	1.732472	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,687,475	7,327,684	19,015,159	0.478317	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	79,192,175	128,208,488	207,400,663	0.794010	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	7,522,236	4,819,110	12,341,346	0.510662	0.000000	74.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	310,760	98,193,716	98,504,476	2.048153	0.000000	90.00	
91.00	09100	EMERGENCY	11,140,400	41,090,100	52,230,500	1.208630	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	10,639,802	16,809,842	27,449,644	0.858942	0.000000	92.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	601,112,019	646,492,473	1,247,604,492			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	601,112,019	646,492,473	1,247,604,492			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet C
Part I
Date/Time Prepared:
5/2/2022 12:01 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
33.00	03300	BURN INTENSIVE CARE UNIT			33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT			34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT			34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT			34.02
34.03	02400	NEURO INTENSIVE CARE			34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT			34.04
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.467446		50.00
51.00	05100	RECOVERY ROOM	0.552122		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3.831671		52.00
53.00	05300	ANESTHESIOLOGY	0.190581		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.433325		54.00
60.00	06000	LABORATORY	0.427244		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.541414		62.00
65.00	06500	RESPIRATORY THERAPY	0.676293		65.00
66.00	06600	PHYSICAL THERAPY	1.083376		66.00
67.00	06700	OCCUPATIONAL THERAPY	1.147095		67.00
68.00	06800	SPEECH PATHOLOGY	1.153785		68.00
69.00	06900	ELECTROCARDIOLOGY	0.364109		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.732472		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.478317		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.794010		73.00
74.00	07400	RENAL DIALYSIS	0.512757		74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	2.075710		90.00
91.00	09100	EMERGENCY	1.214656		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.858942		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet C
Part I
Date/Time Prepared:
5/2/2022 12:01 pm

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	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	135,776,033		135,776,033	1,347,457	137,123,490	30.00
31.00	03100	INTENSIVE CARE UNIT	19,470,422		19,470,422	0	19,470,422	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	8,078,879		8,078,879	0	8,078,879	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	8,638,630		8,638,630	72,209	8,710,839	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0		0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	14,044,646		14,044,646	133,061	14,177,707	34.02
34.03	02400	NEURO INTENSIVE CARE	5,292,172		5,292,172	0	5,292,172	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	12,090,340		12,090,340	0	12,090,340	34.04
43.00	04300	NURSERY	6,409,002		6,409,002	0	6,409,002	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	80,424,032		80,424,032	119,427	80,543,459	50.00
51.00	05100	RECOVERY ROOM	8,949,019		8,949,019	0	8,949,019	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,468,698		9,468,698	0	9,468,698	52.00
53.00	05300	ANESTHESIOLOGY	11,342,797		11,342,797	103,897	11,446,694	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	61,798,091		61,798,091	379,445	62,177,536	54.00
60.00	06000	LABORATORY	61,611,362		61,611,362	80,507	61,691,869	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	6,887,037		6,887,037	0	6,887,037	62.00
65.00	06500	RESPIRATORY THERAPY	9,875,613	0	9,875,613	8,308	9,883,921	65.00
66.00	06600	PHYSICAL THERAPY	7,222,694	0	7,222,694	0	7,222,694	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,594,269	0	2,594,269	0	2,594,269	67.00
68.00	06800	SPEECH PATHOLOGY	1,747,791	0	1,747,791	0	1,747,791	68.00
69.00	06900	ELECTROCARDIOLOGY	14,685,717		14,685,717	0	14,685,717	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	29,693,072		29,693,072	0	29,693,072	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,095,281		9,095,281	0	9,095,281	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	164,678,135		164,678,135	0	164,678,135	73.00
74.00	07400	RENAL DIALYSIS	6,302,257		6,302,257	25,860	6,328,117	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	201,752,213		201,752,213	2,714,521	204,466,734	90.00
91.00	09100	EMERGENCY	63,127,360		63,127,360	314,735	63,442,095	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	23,577,656		23,577,656		23,577,656	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	984,633,218	0	984,633,218	5,299,427	989,932,645	200.00
201.00		Less Observation Beds	23,577,656		23,577,656		23,577,656	201.00
202.00		Total (see instructions)	961,055,562	0	961,055,562	5,299,427	966,354,989	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet C
Part I
Date/Time Prepared:
5/2/2022 12:01 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	124,166,100		124,166,100		30.00
31.00	03100	INTENSIVE CARE UNIT	25,574,880		25,574,880		31.00
33.00	03300	BURN INTENSIVE CARE UNIT	4,899,748		4,899,748		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	8,466,060		8,466,060		34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0		0		34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	9,319,016		9,319,016		34.02
34.03	02400	NEURO INTENSIVE CARE	6,858,296		6,858,296		34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	10,784,468		10,784,468		34.04
43.00	04300	NURSERY	6,411,554		6,411,554		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	91,282,988	81,022,319	172,305,307	0.466753	0.000000
51.00	05100	RECOVERY ROOM	5,409,500	10,798,900	16,208,400	0.552122	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,452,126	19,041	2,471,167	3.831671	0.000000
53.00	05300	ANESTHESIOLOGY	36,007,994	24,054,224	60,062,218	0.188851	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,840,208	100,649,204	143,489,412	0.430680	0.000000
60.00	06000	LABORATORY	46,730,867	97,664,191	144,395,058	0.426686	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	8,740,329	3,980,138	12,720,467	0.541414	0.000000
65.00	06500	RESPIRATORY THERAPY	12,264,771	2,350,077	14,614,848	0.675725	0.000000
66.00	06600	PHYSICAL THERAPY	3,692,267	2,974,574	6,666,841	1.083376	0.000000
67.00	06700	OCCUPATIONAL THERAPY	1,325,840	935,760	2,261,600	1.147095	0.000000
68.00	06800	SPEECH PATHOLOGY	543,726	971,106	1,514,832	1.153785	0.000000
69.00	06900	ELECTROCARDIOLOGY	21,921,489	18,411,804	40,333,293	0.364109	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,926,944	6,212,195	17,139,139	1.732472	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,687,475	7,327,684	19,015,159	0.478317	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	79,192,175	128,208,488	207,400,663	0.794010	0.000000
74.00	07400	RENAL DIALYSIS	7,522,236	4,819,110	12,341,346	0.510662	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	310,760	98,193,716	98,504,476	2.048153	0.000000
91.00	09100	EMERGENCY	11,140,400	41,090,100	52,230,500	1.208630	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	10,639,802	16,809,842	27,449,644	0.858942	0.000000
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	601,112,019	646,492,473	1,247,604,492		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	601,112,019	646,492,473	1,247,604,492		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet C
Part I
Date/Time Prepared:
5/2/2022 12:01 pm

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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet D
Part I
Date/Time Prepared:
5/2/2022 12:01 pm

			Title XVIII		Hospital	PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	17,969,885	0	17,969,885	72,279	248.62	30.00	
31.00	INTENSIVE CARE UNIT	2,155,630		2,155,630	8,962	240.53	31.00	
33.00	BURN INTENSIVE CARE UNIT	679,610		679,610	1,647	412.64	33.00	
34.00	SURGICAL INTENSIVE CARE UNIT	849,440		849,440	3,028	280.53	34.00	
34.01	PEDIATRIC INTENSIVE CARE UNIT	0		0	0	0.00	34.01	
34.02	TRAUMA INTENSIVE CARE UNIT	1,636,625		1,636,625	2,972	550.68	34.02	
34.03	NEURO INTENSIVE CARE	470,803		470,803	2,419	194.63	34.03	
34.04	NEONATAL INTENSIVE CARE UNIT	1,134,750		1,134,750	4,164	272.51	34.04	
43.00	NURSERY	682,170		682,170	1,347	506.44	43.00	
200.00	Total (lines 30 through 199)	25,578,913		25,578,913	96,818		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	6,193	1,539,704					30.00
31.00	INTENSIVE CARE UNIT	1,087	261,456					31.00
33.00	BURN INTENSIVE CARE UNIT	76	31,361					33.00
34.00	SURGICAL INTENSIVE CARE UNIT	224	62,839					34.00
34.01	PEDIATRIC INTENSIVE CARE UNIT	0	0					34.01
34.02	TRAUMA INTENSIVE CARE UNIT	124	68,284					34.02
34.03	NEURO INTENSIVE CARE	201	39,121					34.03
34.04	NEONATAL INTENSIVE CARE UNIT	0	0					34.04
43.00	NURSERY	0	0					43.00
200.00	Total (lines 30 through 199)	7,905	2,002,765					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet D
Part II
Date/Time Prepared:
5/2/2022 12:01 pm

Cost Center Description			Title XVIII		Hospital	PPS	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,271,494	172,305,307	0.048005	11,641,684	558,859
51.00	05100	RECOVERY ROOM	1,026,072	16,208,400	0.063305	543,642	34,415
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,045,380	2,471,167	0.423031	0	0
53.00	05300	ANESTHESIOLOGY	857,428	60,062,218	0.014276	4,614,500	65,877
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,408,440	143,489,412	0.051631	6,528,679	337,082
60.00	06000	LABORATORY	7,099,028	144,395,058	0.049164	8,828,431	434,041
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	672,147	12,720,467	0.052840	783,366	41,393
65.00	06500	RESPIRATORY THERAPY	1,289,055	14,614,848	0.088202	3,703,425	326,649
66.00	06600	PHYSICAL THERAPY	563,619	6,666,841	0.084541	779,800	65,925
67.00	06700	OCCUPATIONAL THERAPY	305,307	2,261,600	0.134996	292,103	39,433
68.00	06800	SPEECH PATHOLOGY	177,439	1,514,832	0.117134	142,439	16,684
69.00	06900	ELECTROCARDIOLOGY	1,834,811	40,333,293	0.045491	3,585,082	163,089
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,149,088	17,139,139	0.183737	2,320,462	426,355
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	461,261	19,015,159	0.024258	1,591,127	38,598
73.00	07300	DRUGS CHARGED TO PATIENTS	11,843,513	207,400,663	0.057105	12,692,831	724,824
74.00	07400	RENAL DIALYSIS	432,544	12,341,346	0.035048	2,417,991	84,746
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	19,478,281	98,504,476	0.197740	0	0
91.00	09100	EMERGENCY	6,223,499	52,230,500	0.119154	1,628,965	194,098
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,089,828	27,449,644	0.112563	1,954,896	220,049
200.00		Total (lines 50 through 199)	75,228,234	1,051,124,370		64,049,423	3,772,117

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0124		Period: From 12/01/2020 To 11/30/2021		Worksheet D Part III Date/Time Prepared: 5/2/2022 12:01 pm	
					Title XVIII		Hospital		PPS	
Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00	
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	0	33.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	0	34.00	
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	0	0	34.01	
34.02	02180	TRAUMA INTENSIVE CARE UNIT	0	0	0	0	0	0	34.02	
34.03	02400	NEURO INTENSIVE CARE	0	0	0	0	0	0	34.03	
34.04	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	0	34.04	
43.00	04300	NURSERY	0	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days			
			4.00	5.00	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	72,279	0.00	6,193	0	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	8,962	0.00	1,087	0	31.00	
33.00	03300	BURN INTENSIVE CARE UNIT		0	1,647	0.00	76	0	33.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	3,028	0.00	224	0	34.00	
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT		0	0	0.00	0	0	34.01	
34.02	02180	TRAUMA INTENSIVE CARE UNIT		0	2,972	0.00	124	0	34.02	
34.03	02400	NEURO INTENSIVE CARE		0	2,419	0.00	201	0	34.03	
34.04	02060	NEONATAL INTENSIVE CARE UNIT		0	4,164	0.00	0	0	34.04	
43.00	04300	NURSERY		0	1,347	0.00	0	0	43.00	
200.00		Total (lines 30 through 199)		0	96,818		7,905	0	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)							
			9.00							
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0						30.00	
31.00	03100	INTENSIVE CARE UNIT	0						31.00	
33.00	03300	BURN INTENSIVE CARE UNIT	0						33.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0						34.00	
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0						34.01	
34.02	02180	TRAUMA INTENSIVE CARE UNIT	0						34.02	
34.03	02400	NEURO INTENSIVE CARE	0						34.03	
34.04	02060	NEONATAL INTENSIVE CARE UNIT	0						34.04	
43.00	04300	NURSERY	0						43.00	
200.00		Total (lines 30 through 199)	0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet D
Part IV
Date/Time Prepared:
5/2/2022 12:01 pm

Cost Center Description			Title XVIII		Hospital		PPS
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	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
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0
60.00	06000	LABORATORY	0	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	469,702
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
200.00		Total (lines 50 through 199)	0	0	0	0	469,702

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet D
Part IV
Date/Time Prepared:
5/2/2022 12:01 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	172,305,307	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	16,208,400	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,471,167	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	60,062,218	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	143,489,412	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	144,395,058	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	12,720,467	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,614,848	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,666,841	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,261,600	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,514,832	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	40,333,293	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	17,139,139	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	19,015,159	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	469,702	469,702	207,400,663	0.002265	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	12,341,346	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	98,504,476	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	52,230,500	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	27,449,644	0.000000	92.00
200.00		Total (lines 50 through 199)	0	469,702	469,702	1,051,124,370		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet D
Part IV
Date/Time Prepared:
5/2/2022 12:01 pm

				Title XVIII		Hospital	PPS			
Cost Center Description				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	11,641,684	0	77,781	0	50.00		
51.00	05100	RECOVERY ROOM	0.000000	543,642	0	567,807	0	51.00		
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00		
53.00	05300	ANESTHESIOLOGY	0.000000	4,614,500	0	1,058,808	0	53.00		
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	6,528,679	0	5,509,596	0	54.00		
60.00	06000	LABORATORY	0.000000	8,828,431	0	3,607,172	0	60.00		
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	783,366	0	63,621	0	62.00		
65.00	06500	RESPIRATORY THERAPY	0.000000	3,703,425	0	142,626	0	65.00		
66.00	06600	PHYSICAL THERAPY	0.000000	779,800	0	5,373	0	66.00		
67.00	06700	OCCUPATIONAL THERAPY	0.000000	292,103	0	794	0	67.00		
68.00	06800	SPEECH PATHOLOGY	0.000000	142,439	0	1,620	0	68.00		
69.00	06900	ELECTROCARDIOLOGY	0.000000	3,585,082	0	1,073,534	0	69.00		
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	2,320,462	0	317,843	0	71.00		
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,591,127	0	381,173	0	72.00		
73.00	07300	DRUGS CHARGED TO PATIENTS	0.002265	12,692,831	28,749	13,132,188	29,744	73.00		
74.00	07400	RENAL DIALYSIS	0.000000	2,417,991	0	1,469,009	0	74.00		
	OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000	0	0	12,277,511	0	90.00		
91.00	09100	EMERGENCY	0.000000	1,628,965	0	1,511,813	0	91.00		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,954,896	0	1,082,854	0	92.00		
200.00		Total (lines 50 through 199)		64,049,423	28,749	42,281,123	29,744	200.00		

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet D
Part V
Date/Time Prepared:
5/2/2022 12:01 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	0.466753	77,781	0	0	36,305	50.00
51.00	05100	RECOVERY ROOM	0.552122	567,807	0	0	313,499	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3.831671	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.188851	1,058,808	0	0	199,957	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.430680	5,509,596	0	0	2,372,873	54.00
60.00	06000	LABORATORY	0.426686	3,607,172	0	0	1,539,130	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.541414	63,621	0	0	34,445	62.00
65.00	06500	RESPIRATORY THERAPY	0.675725	142,626	0	0	96,376	65.00
66.00	06600	PHYSICAL THERAPY	1.083376	5,373	0	0	5,821	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.147095	794	0	0	911	67.00
68.00	06800	SPEECH PATHOLOGY	1.153785	1,620	0	0	1,869	68.00
69.00	06900	ELECTROCARDIOLOGY	0.364109	1,073,534	0	0	390,883	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.732472	317,843	0	0	550,654	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.478317	381,173	0	0	182,322	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.794010	13,132,188	187,766	28,175	10,427,089	73.00
74.00	07400	RENAL DIALYSIS	0.510662	1,469,009	0	0	750,167	74.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2.048153	12,277,511	288	0	25,146,221	90.00
91.00	09100	EMERGENCY	1.208630	1,511,813	0	0	1,827,223	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.858942	1,082,854	0	0	930,109	92.00
200.00		Subtotal (see instructions)		42,281,123	188,054	28,175	44,805,854	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		42,281,123	188,054	28,175	44,805,854	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet D
Part V
Date/Time Prepared:
5/2/2022 12:01 pm

				Title XVIII	Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	149,088	22,371		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	590	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	149,678	22,371		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	149,678	22,371		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet D
Part V
Date/Time Prepared:
5/2/2022 12:01 pm

			Title XIX		Hospital		Cost		
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.466753	0	1,003,980	0	0	50.00	
51.00	05100	RECOVERY ROOM	0.552122	0	3,809,683	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	3.831671	0	6,717	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.188851	0	9,197,874	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.430680	0	29,970,263	0	0	54.00	
60.00	06000	LABORATORY	0.426686	0	40,044,774	0	0	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.541414	0	863,792	0	0	62.00	
65.00	06500	RESPIRATORY THERAPY	0.675725	0	858,483	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	1.083376	0	1,155,515	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	1.147095	0	353,497	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	1.153785	0	362,176	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.364109	0	4,113,410	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.732472	0	2,734,482	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.478317	0	3,225,498	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.794010	0	31,803,529	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0.510662	0	0	0	0	74.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2.048153	0	27,083,820	0	0	90.00	
91.00	09100	EMERGENCY	1.208630	0	19,770,142	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.858942	0	7,612,070	0	0	92.00	
200.00		Subtotal (see instructions)		0	183,969,705	0	0	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		0	183,969,705	0	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet D
Part V
Date/Time Prepared:
5/2/2022 12:01 pm

			Title XIX		Hospital	Cost
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	468,611	0		50.00
51.00	05100	RECOVERY ROOM	2,103,410	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	25,737	0		52.00
53.00	05300	ANESTHESIOLOGY	1,737,028	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,907,593	0		54.00
60.00	06000	LABORATORY	17,086,544	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	467,669	0		62.00
65.00	06500	RESPIRATORY THERAPY	580,098	0		65.00
66.00	06600	PHYSICAL THERAPY	1,251,857	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	405,495	0		67.00
68.00	06800	SPEECH PATHOLOGY	417,873	0		68.00
69.00	06900	ELECTROCARDIOLOGY	1,497,730	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,737,413	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,542,811	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,252,320	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	55,471,807	0		90.00
91.00	09100	EMERGENCY	23,894,787	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,538,327	0		92.00
200.00		Subtotal (see instructions)	156,387,110	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	156,387,110	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0124	Period: From 12/01/2020 To 11/30/2021	Worksheet D-1 Date/Time Prepared: 5/2/2022 12:01 pm
Cost Center Description		Title XVIII	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		72,279	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		72,279	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)		59,851	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		6,193	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)		137,123,490	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)		137,123,490	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)		137,123,490	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,897.14	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		11,748,988	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)		11,748,988	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021

Worksheet D-1

Date/Time Prepared:
5/2/2022 12:01 pm

		Title XVIII		Hospital	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
	Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT	19,470,422	8,962	2,172.55	1,087	2,361,562
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT	8,078,879	1,647	4,905.21	76	372,796
46.00	SURGICAL INTENSIVE CARE UNIT	8,710,839	3,028	2,876.76	224	644,394
46.01	PEDIATRIC INTENSIVE CARE UNIT	0	0	0.00	0	0
46.02	TRAUMA INTENSIVE CARE UNIT	14,177,707	2,972	4,770.43	124	591,533
46.03	NEURO INTENSIVE CARE	5,292,172	2,419	2,187.75	201	439,738
46.04	NEONATAL INTENSIVE CARE UNIT	12,090,340	4,164	2,903.54	0	0
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					38,557,752
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					54,716,763
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					2,002,765
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					3,800,866
52.00	Total Program excludable cost (sum of lines 50 and 51)					5,803,631
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					48,913,132
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)					
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					
72.00	Program routine service cost (line 9 x line 71)					
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					
76.00	Per diem capital-related costs (line 75 ÷ line 2)					
77.00	Program capital-related costs (line 9 x line 76)					
78.00	Inpatient routine service cost (line 74 minus line 77)					
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					
81.00	Inpatient routine service cost per diem limitation					
82.00	Inpatient routine service cost limitation (line 9 x line 81)					
83.00	Reasonable inpatient routine service costs (see instructions)					
84.00	Program inpatient ancillary services (see instructions)					
85.00	Utilization review - physician compensation (see instructions)					
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					12,428
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,897.14
89.00	Observation bed cost (line 87 x line 88) (see instructions)					23,577,656

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021

Worksheet D-1

Date/Time Prepared:
5/2/2022 12:01 pm

Cost Center Description		Title XVIII		Hospital	PPS	
		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	17,969,885	137,123,490	0.131049	23,577,656	3,089,828
91.00	Nursing Program cost	0	137,123,490	0.000000	23,577,656	0
92.00	Allied health cost	0	137,123,490	0.000000	23,577,656	0
93.00	All other Medical Education	0	137,123,490	0.000000	23,577,656	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0124	Period: From 12/01/2020 To 11/30/2021	Worksheet D-1 Date/Time Prepared: 5/2/2022 12:01 pm
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			72,279 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			72,279 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)			59,851 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)			7,900 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			1,347 15.00
16.00	Nursery days (title V or XIX only)			375 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)			135,776,033 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)			135,776,033 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)			135,776,033 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,878.50 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			14,840,150 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)			14,840,150 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021

Worksheet D-1

Date/Time Prepared:
5/2/2022 12:01 pm

		Title XIX		Hospital		Cost	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	6,409,002	1,347	4,757.98	375	1,784,243	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	19,470,422	8,962	2,172.55	1,931	4,195,194	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT	8,078,879	1,647	4,905.21	105	515,047	45.00
46.00	SURGICAL INTENSIVE CARE UNIT	8,638,630	3,028	2,852.92	252	718,936	46.00
46.01	PEDIATRIC INTENSIVE CARE UNIT	0	0	0.00	0	0	46.01
46.02	TRAUMA INTENSIVE CARE UNIT	14,044,646	2,972	4,725.65	358	1,691,783	46.02
46.03	NEURO INTENSIVE CARE	5,292,172	2,419	2,187.75	170	371,918	46.03
46.04	NEONATAL INTENSIVE CARE UNIT	12,090,340	4,164	2,903.54	418	1,213,680	46.04
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					95,847,243	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					121,178,194	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						0 54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)						0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0 57.00
58.00	Bonus payment (see instructions)						0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0 61.00
62.00	Relief payment (see instructions)						0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					12,428	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,878.50	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					23,345,998	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021

Worksheet D-1

Date/Time Prepared:
5/2/2022 12:01 pm

Cost Center Description		Title XIX		Hospital		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	17,969,885	135,776,033	0.132349	23,345,998	3,089,819	90.00
91.00	Nursing Program cost	0	135,776,033	0.000000	23,345,998	0	91.00
92.00	Allied health cost	0	135,776,033	0.000000	23,345,998	0	92.00
93.00	All other Medical Education	0	135,776,033	0.000000	23,345,998	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0124	Period: From 12/01/2020 To 11/30/2021	Worksheet D-3 Date/Time Prepared: 5/2/2022 12:01 pm	
Cost Center Description			Title XVIII	Hospital	PPS	
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		26,656,037		30.00
31.00	03100	INTENSIVE CARE UNIT		3,389,400		31.00
33.00	03300	BURN INTENSIVE CARE UNIT		502,526		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		1,143,342		34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT		0		34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT		915,094		34.02
34.03	02400	NEURO INTENSIVE CARE		1,282,633		34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT		0		34.04
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.467446	11,641,684	5,441,859	50.00
51.00	05100	RECOVERY ROOM	0.552122	543,642	300,157	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3.831671	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.190581	4,614,500	879,436	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.433325	6,528,679	2,829,040	54.00
60.00	06000	LABORATORY	0.427244	8,828,431	3,771,894	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.541414	783,366	424,125	62.00
65.00	06500	RESPIRATORY THERAPY	0.676293	3,703,425	2,504,600	65.00
66.00	06600	PHYSICAL THERAPY	1.083376	779,800	844,817	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.147095	292,103	335,070	67.00
68.00	06800	SPEECH PATHOLOGY	1.153785	142,439	164,344	68.00
69.00	06900	ELECTROCARDIOLOGY	0.364109	3,585,082	1,305,361	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.732472	2,320,462	4,020,135	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.478317	1,591,127	761,063	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.794010	12,692,831	10,078,235	73.00
74.00	07400	RENAL DIALYSIS	0.512757	2,417,991	1,239,842	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.075710	0	0	90.00
91.00	09100	EMERGENCY	1.214656	1,628,965	1,978,632	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.858942	1,954,896	1,679,142	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		64,049,423	38,557,752	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		64,049,423		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0124	Period: From 12/01/2020 To 11/30/2021	Worksheet D-3 Date/Time Prepared: 5/2/2022 12:01 pm
Cost Center Description			Title XIX	Hospital	Cost
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		65,639,706	30.00
31.00	03100	INTENSIVE CARE UNIT		16,046,260	31.00
33.00	03300	BURN INTENSIVE CARE UNIT		870,661	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		2,092,153	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT		0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT		2,971,371	34.02
34.03	02400	NEURO INTENSIVE CARE		1,416,161	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT		3,476,226	34.04
43.00	04300	NURSERY		3,118,977	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.466753	40,365,464	18,840,701 50.00
51.00	05100	RECOVERY ROOM	0.552122	1,370,605	756,741 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3.831671	621,295	2,380,598 52.00
53.00	05300	ANESTHESIOLOGY	0.188851	16,566,584	3,128,616 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.430680	15,850,154	6,826,344 54.00
60.00	06000	LABORATORY	0.426686	23,707,737	10,115,759 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.541414	2,064,778	1,117,900 62.00
65.00	06500	RESPIRATORY THERAPY	0.675725	5,211,690	3,521,669 65.00
66.00	06600	PHYSICAL THERAPY	1.083376	1,699,958	1,841,694 66.00
67.00	06700	OCCUPATIONAL THERAPY	1.147095	618,294	709,242 67.00
68.00	06800	SPEECH PATHOLOGY	1.153785	234,801	270,910 68.00
69.00	06900	ELECTROCARDIOLOGY	0.364109	5,889,786	2,144,524 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.732472	5,643,692	9,777,538 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.478317	6,036,501	2,887,361 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.794010	33,551,319	26,640,083 73.00
74.00	07400	RENAL DIALYSIS	0.510662	2,515,936	1,284,793 74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	2.048153	0	0 90.00
91.00	09100	EMERGENCY	1.208630	121,823	147,239 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.858942	4,023,008	3,455,531 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		166,093,425	95,847,243 200.00
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)		166,093,425	95,847,243 202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0124	Period: From 12/01/2020 To 11/30/2021	Worksheet E Part A Date/Time Prepared: 5/2/2022 12:01 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)		11,833,827	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		2,366,765	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		1,503,951	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		300,790	2.04
3.00	Managed Care Simulated Payments		11,914,608	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		397.95	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		522.08	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		36.60	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		-93.24	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)		392.24	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		430.65	10.00
11.00	FTE count for residents in dental and podiatric programs.		5.38	11.00
12.00	Current year allowable FTE (see instructions)		397.62	12.00
13.00	Total allowable FTE count for the prior year.		403.32	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.		409.59	14.00
15.00	Sum of lines 12 through 14 divided by 3.		403.51	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		403.51	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		1.013972	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.949009	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.949009	21.00
22.00	IME payment adjustment (see instructions)		5,948,926	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		4,991,279	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)		38.41	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)		5,948,926	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		4,991,279	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		14.93	30.00
31.00	Percentage of Medicaid patient days (see instructions)		48.33	31.00
32.00	Sum of lines 30 and 31		63.26	32.00
33.00	Allowable disproportionate share percentage (see instructions)		41.81	33.00
34.00	Disproportionate share adjustment (see instructions)		1,484,317	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0124	Period: From 12/01/2020 To 11/30/2021	Worksheet E Part A Date/Time Prepared: 5/2/2022 12:01 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)	76,429,439	108,435,404	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	63,656,322	18,122,050	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	81,778,372		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)		0	40.00
			Before 1/1	On/After 1/1
			1.00	1.01
41.00	Total ESRD Medicare discharges (see instructions)		0	0 41.00
41.01	Total ESRD Medicare covered and paid discharges (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 (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)	105,216,948		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)		110,208,227	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,279,130	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).		3,654,473	52.00
53.00	Nursing and Allied Health Managed Care payment		3,920	53.00
54.00	Special add-on payments for new technologies		64,858	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		28,749	58.00
59.00	Total (sum of amounts on lines 49 through 58)		116,239,357	59.00
60.00	Primary payer payments		64,439	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		116,174,918	61.00
62.00	Deductibles billed to program beneficiaries		1,368,716	62.00
63.00	Coinsurance billed to program beneficiaries		152,799	63.00
64.00	Allowable bad debts (see instructions)		1,019,195	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		662,477	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		115,315,880	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 PER PSR		40,298	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)		4,384	70.93
70.94	HRR adjustment amount (see instructions)		-27,810	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0124	Period: From 12/01/2020 To 11/30/2021	Worksheet E Part A Date/Time Prepared: 5/2/2022 12:01 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)		845,910	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		114,486,842	71.00
71.01	Sequestration adjustment (see instructions)		0	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		90,685,082	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)		23,801,760	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)		2,196,067	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		531,744	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	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	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 REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0124	Period: From 12/01/2020 To 11/30/2021	Worksheet E Part B Date/Time Prepared: 5/2/2022 12:01 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		172,049	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		44,776,110	2.00
3.00	OPPS payments		11,318,531	3.00
4.00	Outlier payment (see instructions)		2,098,699	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		29,744	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		172,049	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		216,229	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)		216,229	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)		216,229	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		44,180	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)		172,049	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)		13,446,974	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)		2,401,929	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)		11,217,094	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		3,007,563	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)		14,224,657	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		14,224,657	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)		1,618,407	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		1,051,965	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		15,276,622	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)		15,276,622	40.00
40.01	Sequestration adjustment (see instructions)		0	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		16,930,675	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)		-1,654,053	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)		1,706,810	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet E-1
Part I
Date/Time Prepared:
5/2/2022 12:01 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		90,608,961		16,635,647	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	03/15/2021	69,928	03/15/2021	163,483	3.01
3.02		09/15/2021	6,193	09/15/2021	131,545	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)		76,121		295,028	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)		90,685,082		16,930,675	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		23,801,760		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		1,654,053	6.02
7.00	Total Medicare program liability (see instructions)		114,486,842		15,276,622	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: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet E-1
Part II
Date/Time Prepared:
5/2/2022 12:01 pm

		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet E-3
Part VII
Date/Time Prepared:
5/2/2022 12:01 pm

		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		121,178,194		1.00
2.00	Medical and other services			156,387,110	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		121,178,194	156,387,110	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		121,178,194	156,387,110	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		95,631,515		8.00
9.00	Ancillary service charges		166,093,425	183,969,705	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		261,724,940	183,969,705	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		261,724,940	183,969,705	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		140,546,746	27,582,595	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		121,178,194	156,387,110	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0	0	24.00
25.00	Capital exception payments (see instructions)		0	0	25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		121,178,194	156,387,110	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		121,178,194	156,387,110	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		121,178,194	156,387,110	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		121,178,194	156,387,110	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		121,178,194	156,387,110	40.00
41.00	Interim payments		121,178,194	156,387,110	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0124		Period: From 12/01/2020 To 11/30/2021		Worksheet E-4 Date/Time Prepared: 5/2/2022 12:01 pm	
		Title XVIII		Hospital		PPS	
						1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT							
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.					526.48	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)					0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA					65.83	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)					0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))					-53.24	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)					407.41	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)					430.65	6.00
7.00	Enter the lesser of line 5 or line 6					407.41	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.	196.53	167.99	364.52		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.	185.92	158.92	344.84		9.00	
10.00	Weighted dental and podiatric resident FTE count for the current year		5.13			10.00	
10.01	Unweighted dental and podiatric resident FTE count for the current year		5.38			10.01	
11.00	Total weighted FTE count	185.92	164.05			11.00	
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	166.48	212.33			12.00	
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	166.78	209.88			13.00	
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	173.06	195.42			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	173.06	195.42			17.00	
18.00	Per resident amount	105,590.92	104,696.92			18.00	
19.00	Approved amount for resident costs	18,273,565	20,459,872	38,733,437		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)			23.24		21.00	
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00		22.00	
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00		23.00	
24.00	Multiply line 22 time line 23			0		24.00	
25.00	Total direct GME amount (sum of lines 19 and 24)			38,733,437		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)	7,905	5,704	1,099			26.00
27.00	Total Inpatient Days (see instructions)	83,903	83,903	83,903			27.00
28.00	Ratio of inpatient days to total inpatient days	0.094216	0.067983	0.013098			28.00
29.00	Program direct GME amount	3,649,310	2,633,215	507,331	6,789,856	29.00	
29.01	Percent reduction for MA DGME		4.07	4.07			29.01
30.00	Reduction for direct GME payments for Medicare Advantage		107,172	20,648	127,820	30.00	
31.00	Net Program direct GME amount				6,662,036	31.00	

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0124	Period: From 12/01/2020 To 11/30/2021	Worksheet E-4 Date/Time Prepared: 5/2/2022 12:01 pm
		Title XVIII	Hospital	PPS
			1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM 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)		12,341,346	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)		54,716,763	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)		64,439	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		54,652,324	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		44,977,903	42.00
43.00	Primary payer payments (see instructions)		0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		44,977,903	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		99,630,227	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.548552	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.451448	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		6,662,036	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		3,654,473	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		3,007,563	50.00

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

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021

Worksheet G

Date/Time Prepared:
5/2/2022 12:01 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	430,169,441	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	1,132,213,788	0	0	0	4.00
5.00 Other receivable	13,862,269	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00 Inventory	8,776,469	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)	1,585,021,967	0	0	0	11.00
FIXED ASSETS					
12.00 Land	990,911	0	0	0	12.00
13.00 Land improvements	2,631,393	0	0	0	13.00
14.00 Accumulated depreciation	-2,222,738	0	0	0	14.00
15.00 Buildings	862,450,253	0	0	0	15.00
16.00 Accumulated depreciation	-381,883,023	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	5,689,129	0	0	0	19.00
20.00 Accumulated depreciation	-5,300,394	0	0	0	20.00
21.00 Automobiles and trucks	219,687	0	0	0	21.00
22.00 Accumulated depreciation	-215,522	0	0	0	22.00
23.00 Major movable equipment	172,819,216	0	0	0	23.00
24.00 Accumulated depreciation	-132,972,620	0	0	0	24.00
25.00 Minor equipment depreciable	-14,709,085	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)	507,497,207	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)	2,092,519,174	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	99,042,625	0	0	0	37.00
38.00 Salaries, wages, and fees payable	19,876,550	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	60,480,796	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	0	0	0	0	43.00
44.00 Other current liabilities	68,844,275	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	248,244,246	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	33,279,879	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	33,279,879	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	281,524,125	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	1,810,995,049	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	1,810,995,049	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	2,092,519,174	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021

Worksheet G-1

Date/Time Prepared:
5/2/2022 12:01 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		1,649,236,049		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		171,782,811				2.00
3.00	Total (sum of line 1 and line 2)		1,821,018,860		0		3.00
4.00	OTHER	98,140,622		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00	ROUNDING	1		0		0	9.00
10.00	Total additions (sum of line 4-9)		98,140,623		0		10.00
11.00	Subtotal (line 3 plus line 10)		1,919,159,483		0		11.00
12.00	OTHER	36,784,096		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)		36,784,096		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		1,882,375,387		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	OTHER		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00	ROUNDING		0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	OTHER		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
5/2/2022 12:01 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	130,577,654		130,577,654	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)	130,577,654		130,577,654	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	25,574,880		25,574,880	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT	4,899,748		4,899,748	13.00
14.00	SURGICAL INTENSIVE CARE UNIT	8,466,060		8,466,060	14.00
14.01	PEDIATRIC INTENSIVE CARE UNIT	0		0	14.01
14.02	TRAUMA INTENSIVE CARE UNIT	9,319,016		9,319,016	14.02
14.03	NEURO INTENSIVE CARE	6,858,296		6,858,296	14.03
14.04	NEONATAL INTENSIVE CARE UNIT	10,784,468		10,784,468	14.04
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	65,902,468		65,902,468	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	196,480,122		196,480,122	17.00
18.00	Ancillary services	382,540,934	490,398,815	872,939,749	18.00
19.00	Outpatient services	22,090,962	156,093,658	178,184,620	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN CHARGES	0	207,819,556	207,819,556	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	601,112,018	854,312,029	1,455,424,047	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		934,975,827		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)		934,975,827		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0124

Period:
From 12/01/2020
To 11/30/2021

Worksheet G-3

Date/Time Prepared:
5/2/2022 12:01 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,455,424,047	1.00
2.00	Less contractual allowances and discounts on patients' accounts	716,700,525	2.00
3.00	Net patient revenues (line 1 minus line 2)	738,723,522	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	934,975,827	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-196,252,305	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	0	24.00
24.01	MISC INCOME	13,200,704	24.01
24.02	REVENUE FROM COUNTY	0	24.02
24.03	EHR INCENTIVE REVENUE	858,500	24.03
24.04	GRADUATE MEDICAL EDUCATION	73,660,708	24.04
24.05	CAPITATION REVENUE	277,729,433	24.05
24.50	COVID-19 PHE Funding	66,290	24.50
25.00	Total other income (sum of lines 6-24)	365,515,635	25.00
26.00	Total (line 5 plus line 25)	169,263,330	26.00
27.00	OTHER EXPENSES PER FS	-2,519,481	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-2,519,481	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	171,782,811	29.00

ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

Provider CCN: 14-0124

Period:

Worksheet I-1

Component CCN: 14-2313

From 12/01/2020
To 11/30/2021Date/Time Prepared:
5/2/2022 12:01 pm

		Renal Dialysis			
		Total Costs	Basis	Statistics	FTEs per 2080 Hours
		1.00	2.00	3.00	4.00
1.00	REGISTERED NURSES	888,203	HOURS OF SERVICE	16,283.59	7.83
2.00	LICENSED PRACTICAL NURSES	0	HOURS OF SERVICE	0.00	0.00
3.00	NURSES AIDES	0	HOURS OF SERVICE	0.00	0.00
4.00	TECHNICIANS	292,944	HOURS OF SERVICE	12,219.32	5.87
5.00	SOCIAL WORKERS	0	HOURS OF SERVICE	0.00	0.00
6.00	DIETICIANS	0	HOURS OF SERVICE	0.00	0.00
7.00	PHYSICIANS	150,719	ACCUMULATED COST		7.00
8.00	NON-PATIENT CARE SALARY	324,306	ACCUMULATED COST		8.00
9.00	SUBTOTAL (SUM OF LINES 1-8)	1,656,172			9.00
10.00	EMPLOYEE BENEFITS	0	SALARY		10.00
11.00	CAPITAL RELATED COSTS-BLDGS. & FIXTURES	0	SQUARE FEET		11.00
12.00	CAPITAL RELATED COSTS-MOV. EQUIP.	0	PERCENTAGE OF TIME		12.00
13.00	MACHINE COSTS & REPAIRS	0	PERCENTAGE OF TIME		13.00
14.00	SUPPLIES	4,131	REQUISITIONS		14.00
15.00	DRUGS	0	REQUISITIONS		15.00
16.00	OTHER	164,147	ACCUMULATED COST		16.00
17.00	SUBTOTAL (SUM OF LINES 9-16)*	1,824,450			17.00
18.00	CAPITAL RELATED COSTS-BLDGS. & FIXTURES	50,565	SQUARE FEET		18.00
19.00	CAPITAL RELATED COSTS-MOV. EQUIP.	0	PERCENTAGE OF TIME		19.00
20.00	EMPLOYEE BENEFITS DEPARTMENT	2,313,439	SALARY		20.00
21.00	ADMINISTRATIVE & GENERAL	1,412,410	ACCUMULATED COST		21.00
22.00	MAINT./REPAIRS-OPER-HOUSEKEEPING	202,277	SQUARE FEET		22.00
23.00	MEDICAL EDUCATION PROGRAM COSTS	0			23.00
24.00	CENTRAL SERVICE & SUPPLIES	19,106	REQUISITIONS		24.00
25.00	PHARMACY	0	REQUISITIONS		25.00
26.00	OTHER ALLOCATED COSTS	480,010	ACCUMULATED COST		26.00
27.00	SUBTOTAL (SUM OF LINES 17-26)*	6,302,257			27.00
28.00	LABORATORY (SEE INSTRUCTIONS)	0	CHARGES	0	28.00
29.00	RESPIRATORY THERAPY (SEE INSTRUCTIONS)	0	CHARGES	0	29.00
30.00	OTHER ANCILLARY SERVICE COST CENTERS	0	CHARGES	0	30.00
31.00	TOTAL COSTS (SUM OF LINES 27-30)	6,302,257			31.00

* Line 17, column 1 should agree with Worksheet A, column 7 for line 74 or line 94 as appropriate, and line 27, column 1 should agree with Worksheet B, Part I, column 24, less the sum of columns 21 and 22, for line 74 or line 94 as appropriate.

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES

Provider CCN: 14-0124

Period:

Worksheet I-2

Component CCN: 14-2313

From 12/01/2020
To 11/30/2021Date/Time Prepared:
5/2/2022 12:01 pm

		Capital Related Costs		Direct Patient Care Salary		Renal Dialysis	
		Building	Equipment	RNs	Other	Employee Benefits Department	Drugs
		1.00	2.00	3.00	4.00	5.00	6.00
1.00	Total Renal Department Costs	252,842	0	888,203	292,944	2,313,439	0
MAINTENANCE							
2.00	Hemodialysis	79,796	0	280,313	92,452	730,110	0
2.01	AKI-Hemodialysis	0	0	0	0	0	0
3.00	Intermittent Peritoneal	0	0	0	0	0	0
3.01	AKI-Intermittent Peritoneal	0	0	0	0	0	0
TRAINING							
4.00	Hemodialysis	0	0	0	0	0	0
5.00	Intermittent Peritoneal	0	0	0	0	0	0
6.00	CAPD	0	0	0	0	0	0
7.00	CCPD	753	0	2,643	872	6,885	0
HOME							
8.00	Hemodialysis	0	0	0	0	0	0
9.00	Intermittent Peritoneal	0	0	0	0	0	0
10.00	CAPD	0	0	0	0	0	0
11.00	CCPD	3,070	0	10,785	3,557	28,092	0
OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis	169,223	0	594,462	196,063	1,548,352	0
13.00	Method II Home Patient	0	0	0	0	0	0
14.00	ESAs (included in Renal Department)						0
15.00							15.00
16.00	Other	0	0	0	0	0	0
17.00	Total (sum of lines 2 through 16)	252,842	0	888,203	292,944	2,313,439	0
18.00	Medical Educational Program Costs						18.00
19.00	Total Renal Costs (line 17 + line 18)						19.00
		Medical Supplies	Routine Ancillary Services	Subtotal (sum of cols. 1-8)	Overhead	Total (col. 9 + col. 10)	
		7.00	8.00	9.00	10.00	11.00	
1.00	Total Renal Department Costs	23,237	0	3,770,665	2,531,592	6,302,257	1.00
MAINTENANCE							
2.00	Hemodialysis	7,333	0	1,190,004	798,958	1,988,962	2.00
2.01	AKI-Hemodialysis	0	0	0	0	0	2.01
3.00	Intermittent Peritoneal	0	0	0	0	0	3.00
3.01	AKI-Intermittent Peritoneal	0	0	0	0	0	3.01
TRAINING							
4.00	Hemodialysis	0	0	0	0	0	4.00
5.00	Intermittent Peritoneal	0	0	0	0	0	5.00
6.00	CAPD	0	0	0	0	0	6.00
7.00	CCPD	69	0	11,222	7,534	18,756	7.00
HOME							
8.00	Hemodialysis	0	0	0	0	0	8.00
9.00	Intermittent Peritoneal	0	0	0	0	0	9.00
10.00	CAPD	0	0	0	0	0	10.00
11.00	CCPD	282	0	45,786	30,740	76,526	11.00
OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis	15,553	0	2,523,653	1,694,360	4,218,013	12.00
13.00	Method II Home Patient	0	0	0	0	0	13.00
14.00	ESAs (included in Renal Department)						14.00
15.00							15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Total (sum of lines 2 through 16)	23,237	0	3,770,665	2,531,592	6,302,257	17.00
18.00	Medical Educational Program Costs					0	18.00
19.00	Total Renal Costs (line 17 + line 18)					6,302,257	19.00

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0124

Period:

Worksheet I-3

Component CCN: 14-2313

From 12/01/2020
To 11/30/2021Date/Time Prepared:
5/2/2022 12:01 pm

		Capital Related Costs		Direct Patient Care Salary		Renal Dialysis	
		Building (Square Feet)	Equipment (%) of Time)	RNs (Hours)	Other (Hours)	Employee Benefits Department (Salary)	
		0	1.00	2.00	3.00	4.00	5.00
1.00	Total Renal Department Costs	252,842	0	888,203	292,944	2,313,439	1.00
MAINTENANCE							
2.00	Hemodialysis	2,651	2,651.00	2,651.00	2,651.00	2,651	2.00
2.01	AKI-Hemodialysis	0	0.00	0.00	0.00	0	2.01
3.00	Intermittent Peritoneal	0	0.00	0.00	0.00	0	3.00
3.01	AKI-Intermittent Peritoneal	0	0.00	0.00	0.00	0	3.01
TRAINING							
4.00	Hemodialysis	0	0.00	0.00	0.00	0	4.00
5.00	Intermittent Peritoneal	0	0.00	0.00	0.00	0	5.00
6.00	CAPD	0	0.00	0.00	0.00	0	6.00
7.00	CCPD	25	25.00	25.00	25.00	25	7.00
HOME							
8.00	Hemodialysis	0	0.00	0.00	0.00	0	8.00
9.00	Intermittent Peritoneal	0	0.00	0.00	0.00	0	9.00
10.00	CAPD	0	0.00	0.00	0.00	0	10.00
11.00	CCPD	102	102.00	102.00	102.00	102	11.00
OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis Treatments	5,622	5,622.00	5,622.00	5,622.00	5,622	12.00
13.00	Method II Home Patient	0	0.00	0.00	0.00	0	13.00
14.00	ESAs						14.00
15.00							15.00
16.00	Other	0	0.00	0.00	0.00	0	16.00
17.00	Total Statistical Basis	8,400	8,400.00	8,400.00	8,400.00	8,400	17.00
18.00	Unit Cost Multiplier (line 1 ÷ line 17)	30.100238	0.000000	105.738452	34.874286	275.409405	18.00
		Drugs (Requist.)	Medical Supplies (Requist.)	Routine Ancillary Services (Charges)	Subtotal	Overhead (Accum. Cost)	
		6.00	7.00	8.00	9.00	10.00	
1.00	Total Renal Department Costs	0	23,237	0	3,770,665	2,531,592	1.00
MAINTENANCE							
2.00	Hemodialysis	2,651	2,651	2,651			2.00
2.01	AKI-Hemodialysis	0	0	0			2.01
3.00	Intermittent Peritoneal	0	0	0			3.00
3.01	AKI-Intermittent Peritoneal	0	0	0			3.01
TRAINING							
4.00	Hemodialysis	0	0	0			4.00
5.00	Intermittent Peritoneal	0	0	0			5.00
6.00	CAPD	0	0	0			6.00
7.00	CCPD	25	25	25			7.00
HOME							
8.00	Hemodialysis	0	0	0			8.00
9.00	Intermittent Peritoneal	0	0	0			9.00
10.00	CAPD	0	0	0			10.00
11.00	CCPD	102	102	102			11.00
OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis Treatments	5,622	5,622	5,622			12.00
13.00	Method II Home Patient	0	0	0			13.00
14.00	ESAs						14.00
15.00							15.00
16.00	Other	0	0	0			16.00
17.00	Total Statistical Basis	8,400	8,400	8,400		3,770,665	17.00
18.00	Unit Cost Multiplier (line 1 ÷ line 17)	0.000000	2.766310	0.000000		0.671391	18.00

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

Provider CCN: 14-0124

Period:

Worksheet I-4

Component CCN: 14-2313

From 12/01/2020
To 11/30/2021Date/Time Prepared:
5/2/2022 12:01 pm

		Rate 0		Renal Dialysis		
		Number of Total Treatments	Total Cost (from Wkst. I-2, col. 11)	Average Cost of Treatments (col. 2 ÷ col. 1)	Number of Program Treatments	Total Program Expenses (see instructions)
		1.00	2.00	3.00	4.00	5.00
1.00	Maintenance - Hemodialysis	2,651	1,988,962	750.27	259	194,320
2.00	Maintenance - Peritoneal Dialysis	0	0	0.00	0	0
3.00	Training - Hemodialysis	0	0	0.00	0	0
4.00	Training - Peritoneal Dialysis	0	0	0.00	0	0
5.00	Training - CAPD	0	0	0.00	0	0
6.00	Training - CCPD	25	18,756	750.24	0	0
7.00	Home Program - Hemodialysis	0	0	0.00	0	0
8.00	Home Program - Peritoneal Dialysis	0	0	0.00	0	0
		Patient Weeks			Patient Weeks	
		1.00	2.00	3.00	4.00	5.00
9.00	Home Program - CAPD	0	0	0.00	0	0
10.00	Home Program - CCPD	102	76,526	750.25	0	0
11.00	Totals (sum of lines 1 through 8, cols. 1 and 4) (sum of lines 1 through 10, cols. 2, 5, and 6) (see instruction)	2,676	2,084,244		259	194,320
12.00	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instruction)	2,982				
		Total Program Payment	Average Payment Rate (col. 6 ÷ col. 4)			
		6.00	7.00			
1.00	Maintenance - Hemodialysis	60,766	234.62			
2.00	Maintenance - Peritoneal Dialysis	0	0.00			
3.00	Training - Hemodialysis	0	0.00			
4.00	Training - Peritoneal Dialysis	0	0.00			
5.00	Training - CAPD	0	0.00			
6.00	Training - CCPD	0	0.00			
7.00	Home Program - Hemodialysis	0	0.00			
8.00	Home Program - Peritoneal Dialysis	0	0.00			
		6.00	7.00			
9.00	Home Program - CAPD	0	0.00			
10.00	Home Program - CCPD	0	0.00			
11.00	Totals (sum of lines 1 through 8, cols. 1 and 4) (sum of lines 1 through 10, cols. 2, 5, and 6) (see instruction)	60,766				
12.00	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instruction)					

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B		Provider CCN: 14-0124	Period: From 12/01/2020 To 11/30/2021	Worksheet I-5 Date/Time Prepared: 5/2/2022 12:01 pm
		1.00	2.00	
PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B				
1.00	Total expenses related to care of program beneficiaries (see instructions)	194,320		1.00
2.00	Total payment due (from Wkst. I-4, col. 6, line 11) (see instructions)	60,766	60,766	2.00
2.01	Total payment due (from Wkst. I-4, col. 6.01, line 11) (see instructions)			2.01
2.02	Total payment due (from Wkst. I-4, col. 6.02, line 11) (see instructions)			2.02
2.03	Total payment due (see instructions)	60,766	60,766	2.03
2.04	Outlier payments	0		2.04
3.00	Deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.00
3.01	Deductibles billed to Medicare (Part B) patients (see instructions)			3.01
3.02	Deductibles billed to Medicare (Part B) patients (see instructions)			3.02
3.03	Total deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.03
4.00	Coinsurance billed to Medicare (Part B) patients	24,373	24,373	4.00
4.01	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.01
4.02	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.02
4.03	Total coinsurance billed to Medicare (Part B) patients (see instructions)	24,373	24,373	4.03
5.00	Bad debts for deductibles and coinsurance, net of bad debt recoveries	0	0	5.00
5.01	Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2011 but before 1/1/2012			5.01
5.02	Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013			5.02
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014			5.03
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2014	0	0	5.04
5.05	Allowable bad debts (sum of lines 5 through line 5.04)	0	0	5.05
6.00	Adjusted reimbursable bad debts (see instructions)	0		6.00
7.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		7.00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions)	0	24,373	8.00
9.00	Program payment (see instructions)	0	48,613	9.00
10.00	Unrecovered from Medicare (Part B) patients (see instructions)			10.00
11.00	Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)	0		11.00
PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE				
12.00	Total allowable expenses (see instructions)	2,084,244		12.00
13.00	Total composite costs (from Wkst. I-4, col. 2, line 11)	2,084,244		13.00
14.00	Facility specific composite cost percentage (line 13 divided by line 12)	1.000000		14.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0124	Period: From 12/01/2020 To 11/30/2021	Worksheet L Parts I-III Date/Time Prepared: 5/2/2022 12:01 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,086,815	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		470,995	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)		229.87	3.00
4.00	Number of interns & residents (see instructions)		403.51	4.00
5.00	Indirect medical education percentage (see instructions)		52.70	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		572,752	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		14.93	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		48.33	8.00
9.00	Sum of lines 7 and 8		63.26	9.00
10.00	Allowable disproportionate share percentage (see instructions)		13.67	10.00
11.00	Disproportionate share adjustment (see instructions)		148,568	11.00
12.00	Total prospective capital payments (see instructions)		2,279,130	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