

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0300	Period: From 12/01/2020 To 11/30/2021	Worksheet S Parts I-III Date/Time Prepared: 5/2/2022 11:40 am
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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.		Date: 5/2/2022 Time: 11:40 am
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION 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 PROVIDENT HOSPITAL (14-0300) 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	1,677,082	52,978	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
10.00 RURAL HEALTH CLINIC I	0		0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00 Total	0	1,677,082	52,978	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0300		Period: From 12/01/2020 To 11/30/2021		Worksheet S-2 Part I Date/Time Prepared: 5/2/2022 11:40 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 500 EAST 51ST STREET			PO Box:				1.00	
2.00	City: CHICAGO			State: IL		Zip Code: 60615-		County: COOK 2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
								8.00	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			PROVIDENT HOSPITAL	140300	16984	1	10/08/1993	N P O
4.00	Subprovider - IPF								3.00
5.00	Subprovider - IRF								4.00
6.00	Subprovider - (Other)								5.00
7.00	Swing Beds - SNF								6.00
8.00	Swing Beds - NF								7.00
9.00	Hospital-Based SNF								8.00
10.00	Hospital-Based NF								9.00
11.00	Hospital-Based OLTC								10.00
12.00	Hospital-Based HHA								11.00
13.00	Separately Certified ASC								12.00
14.00	Hospital-Based Hospice								13.00
15.00	Hospital-Based Health Clinic - RHC								14.00
16.00	Hospital-Based Health Clinic - FQHC								15.00
17.00	Hospital-Based (CMHC) I								16.00
17.10	Hospital-Based (CORF) I								17.00
18.00	Renal Dialysis			PROVIDENT DIALYSIS CENTER	143531	16984		04/13/2021	17.10
19.00	Other								18.00
							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)						13		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03
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: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet S-2
Part I
Date/Time Prepared:
5/2/2022 11:40 am

	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.	24	0	0	0	401	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 1.00	Date of Geogr 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: 1.00	Ending: 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 1.00	Y/N 2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V 1.00	XVIII 2.00	XIX 3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	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: 14-0300		Period: From 12/01/2020 To 11/30/2021		Worksheet S-2 Part I Date/Time Prepared: 5/2/2022 11:40 am	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			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
61.01	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
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00
						0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet S-2
Part I
Date/Time Prepared:
5/2/2022 11:40 am

	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	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			1.00	2.00	3.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
			1.00	2.00	3.00	
			1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS					
	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
	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0300	Period: From 12/01/2020 To 11/30/2021	Worksheet S-2 Part I Date/Time Prepared: 5/2/2022 11:40 am			
			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.			N 86.00			
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N 87.00			
			V	XIX			
			1.00	2.00			
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N Y 90.00			
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N N 91.00			
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N 92.00			
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N N 93.00			
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N N 94.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00 0.00 95.00			
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N N 96.00			
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00 0.00 97.00			
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N Y 98.00			
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N Y 98.01			
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N Y 98.02			
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N N 98.03			
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N N 98.04			
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N Y 98.05			
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N Y 98.06			
Rural Providers							
105.00	Does this hospital qualify as a CAH?			N 105.00			
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			N 106.00			
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 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)			N 107.00			
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N 108.00			
			Physical	Occupational	Speech	Respiratory	
			1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			N	N	N	N
			1.00				
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0300	Period: From 12/01/2020 To 11/30/2021	Worksheet S-2 Part I Date/Time Prepared: 5/2/2022 11:40 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	277,428	155,000	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB2320	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0300		Period: From 12/01/2020 To 11/30/2021		Worksheet S-2 Part I Date/Time Prepared: 5/2/2022 11:40 am	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name: COOK COUNTY		Contractor's Name: NATIONAL GOVERNMENT SERVICES INC		Contractor's Number: 00131				141.00
142.00	Street: 1340 S. DAMEN AVE SUITE 215		PO Box:						142.00
143.00	City: CHICAGO		State: IL		Zip Code: 60608		143.00		
								1.00	
144.00 Are provider based physicians' costs included in Worksheet A?								Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				N		Y		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N				146.00
								1.00	
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital			N	N	N	N		155.00
156.00	Subprovider - IPF			N	N	N	N		156.00
157.00	Subprovider - IRF			N	N	N	N		157.00
158.00	SUBPROVIDER								158.00
159.00	SNF			N	N	N	N		159.00
160.00	HOME HEALTH AGENCY			N	N	N	N		160.00
161.00	CMHC				N	N	N		161.00
161.10	CORF				N	N	N		161.10
								1.00	
Multicampus									
165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	167.00
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)									168.00
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								9.99	169.00
						Beginning	Ending		
						1.00	2.00		
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)									170.00
						1.00	2.00		
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)								N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0300	Period: From 12/01/2020 To 11/30/2021	Worksheet S-2 Part II Date/Time Prepared: 5/2/2022 11:40 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for 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.	N		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.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	03/31/2022	Y 03/31/2022
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet S-2
Part II
Date/Time Prepared:
5/2/2022 11:40 am

		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: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet S-2
Part II
Date/Time Prepared:
5/2/2022 11:40 am

		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: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet S-3
Part I
Date/Time Prepared:
5/2/2022 11:40 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		25	9,125	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet S-3
Part I
Date/Time Prepared:
5/2/2022 11:40 am

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)	168	24	1,632			1.00
2.00	HMO and other (see instructions)	83	401				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)	168	24	1,632			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	0			13.00
14.00	Total (see instructions)	168	24	1,632	6.02	355.76	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				6.02	355.76	27.00
28.00	Observation Bed Days		0	924			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet S-3
Part I
Date/Time Prepared:
5/2/2022 11:40 am

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	56	9	340	1.00
2.00 HMO and other (see instructions)			30	119		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	56	9	340	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00					25.10
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet S-3
Part II
Date/Time Prepared:
5/2/2022 11:40 am

	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	33,461,991	0	33,461,991	686,169.00	48.77
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		2,325,396	0	2,325,396	45,898.00	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)		17,384,441	0	17,384,441		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		0	0	0		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		434,066	0	434,066		
22.01	Physician Part A - Teaching		91,109	0	91,109		
23.00	Physician Part B		3,891,918	0	3,891,918		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		911,087	0	911,087		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet S-3
Part II
Date/Time Prepared:
5/2/2022 11:40 am

		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	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	1,991,545	-600,112	1,391,433	48,565.00	28.65	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,805,126	0	2,805,126	51,477.00	54.49	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	828,576	0	828,576	38,082.00	21.76	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	919,687	0	919,687	17,644.00	52.12	38.00
39.00	Central Services and Supply	14.00	262,371	0	262,371	11,499.00	22.82	39.00
40.00	Pharmacy	15.00	2,508,925	0	2,508,925	50,553.00	49.63	40.00
41.00	Medical Records & Medical Records Library	16.00	61,570	0	61,570	2,303.00	26.73	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet S-3
Part III
Date/Time Prepared:
5/2/2022 11:40 am

	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)	33,461,991	0	33,461,991	686,169.00	48.77	1.00
2.00	Excluded area salaries (see instructions)	0	0	0	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)	33,461,991	0	33,461,991	686,169.00	48.77	3.00
4.00	Subtotal other wages & related costs (see inst.)	2,325,396	0	2,325,396	45,898.00	50.66	4.00
5.00	Subtotal wage-related costs (see inst.)	18,729,594	0	18,729,594	0.00	55.97	5.00
6.00	Total (sum of lines 3 thru 5)	54,516,981	0	54,516,981	732,067.00	74.47	6.00
7.00	Total overhead cost (see instructions)	9,377,800	-600,112	8,777,688	220,123.00	39.88	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet S-3
Part IV
Date/Time Prepared:
5/2/2022 11:40 am

		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)	9,051,214	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	2,557,263	6.00
7.00	Employee Managed Care Program Administration Fees	1,243,627	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)	6,226,176	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	1,559,488	9.00
10.00	Dental, Hearing and Vision Plan	199,064	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	51,369	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	410,782	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	488,355	18.00
19.00	Unemployment Insurance	14,197	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	21,801,535	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet S-3
Part V
Date/Time Prepared:
5/2/2022 11:40 am

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	0	21,801,534	1.00
2.00	Hospital	0	17,384,441	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	4,417,093	18.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

Provider CCN: 14-0300

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

Worksheet S-5

Date/Time Prepared:
5/2/2022 11:40 am

		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	0	0	0	0	0	0	1.00	
2.00	Number of times per week patient receives dialysis	0.00	0.00	0.00	0.00	0.00	0.00	2.00	
3.00	Average patient dialysis time including setup	0.00	0.00	0.00	0.00			3.00	
4.00	CAPD exchanges per day				0.00		0.00	4.00	
5.00	Number of days in year dialysis furnished	0	0					5.00	
6.00	Number of stations	12	0	0		0		6.00	
7.00	Treatment capacity per day per station	0	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: 14-0300

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

Worksheet S-5

Date/Time Prepared:
5/2/2022 11:40 am

		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)	143531	1,063	23.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0300	Period: From 12/01/2020 To 11/30/2021	Worksheet S-10 Date/Time Prepared: 5/2/2022 11:40 am
				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)			0.812852 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			2,498,787 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	29,872,386		6.00
7.00	Medicaid cost (line 1 times line 6)	24,281,829		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)	21,783,042		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP	0		9.00
10.00	Stand-alone CHIP charges	0		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0		12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	1,059,914		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	1,049,133		14.00
15.00	State or local indigent care program cost (line 1 times line 14)	852,790		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care	0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	21,783,042		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)	6,314,873	0	6,314,873 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	5,133,057	0	5,133,057 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)	5,133,057	0	5,133,057 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)	8,329,469		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	71,939		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	110,675		27.01
28.00	Non-Medicare bad debt expense (see instructions)	8,218,794		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	6,719,399		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	11,852,456		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	33,635,498		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0300

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

Worksheet A

Date/Time Prepared:
5/2/2022 11:40 am

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		829,448	829,448	0	829,448	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		252,249	252,249	0	252,249	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	7,125,059	7,125,059	0	7,125,059	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,991,545	7,004,942	8,996,487	-600,112	8,396,375	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	2,805,126	5,002,269	7,807,395	-741,909	7,065,486	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	112,470	112,470	194,000	306,470	8.00
9.00	00900	HOUSEKEEPING	828,576	209,363	1,037,939	-194,000	843,939	9.00
10.00	01000	DIETARY	0	718,284	718,284	-718,284	0	10.00
11.00	01100	CAFETERIA	0	0	0	718,284	718,284	11.00
13.00	01300	NURSING ADMINISTRATION	919,687	1,195,370	2,115,057	0	2,115,057	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	262,371	1,810,082	2,072,453	-1,733,714	338,739	14.00
15.00	01500	PHARMACY	2,508,925	150,047	2,658,972	0	2,658,972	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	61,570	0	61,570	0	61,570	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	223,525	223,525	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,094,297	0	3,094,297	568,628	3,662,925	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,856,553	0	3,856,553	-57,765	3,798,788	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	349,208	0	349,208	0	349,208	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,166,561	336,113	2,502,674	0	2,502,674	54.00
60.00	06000	LABORATORY	1,135,136	46,006	1,181,142	0	1,181,142	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	541,134	272,359	813,493	0	813,493	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	398,502	137,182	535,684	0	535,684	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,296,783	1,296,783	1,733,714	3,030,497	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,084,204	3,084,204	0	3,084,204	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	741,909	741,909	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	6,250,891	34,646	6,285,537	0	6,285,537	90.00
91.00	09100	EMERGENCY	6,291,909	0	6,291,909	-134,276	6,157,633	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,461,991	29,616,876	63,078,867	0	63,078,867	118.00
NONREIMBURSABLE COST CENTERS								
200.00		TOTAL (SUM OF LINES 118 through 199)	33,461,991	29,616,876	63,078,867	0	63,078,867	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0300

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

Worksheet A

Date/Time Prepared:
5/2/2022 11:40 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,679,827	2,509,275	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	696,164	948,413	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,675,384	16,800,443	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,706,981	12,103,356	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	7,065,486	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	306,470	8.00
9.00	00900	HOUSEKEEPING	0	843,939	9.00
10.00	01000	DIETARY	0	0	10.00
11.00	01100	CAFETERIA	0	718,284	11.00
13.00	01300	NURSING ADMINISTRATION	64,211	2,179,268	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	338,739	14.00
15.00	01500	PHARMACY	-116,979	2,541,993	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	61,570	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	-63,603	159,922	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,146,466	2,516,459	30.00
43.00	04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-1,962,515	1,836,273	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	-315,762	33,446	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-745,520	1,757,154	54.00
60.00	06000	LABORATORY	-152,183	1,028,959	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
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	813,493	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	-375,000	160,684	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,030,497	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,084,204	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,068	45,068	73.00
74.00	07400	RENAL DIALYSIS	0	741,909	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	-1,956,985	4,328,552	90.00
91.00	09100	EMERGENCY	-2,853,725	3,303,908	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,178,897	69,257,764	118.00
NONREIMBURSABLE COST CENTERS					
200.00		TOTAL (SUM OF LINES 118 through 199)	6,178,897	69,257,764	200.00

RECLASSIFICATIONS

Provider CCN: 14-0300

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

Worksheet A-6

Date/Time Prepared:
5/2/2022 11:40 am

Increases					
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	0	718,284	1.00
	0		0	718,284	
B - TEACHING					
1.00	I&R SERVICES-OTHER PRGM	22.00	223,525	0	1.00
2.00	COSTS APPRV	0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		223,525	0	
C - MEDICAL DIRECTOR					
1.00	ADULTS & PEDIATRICS	30.00	272,121	0	1.00
	0		272,121	0	
D - TRANSPORTERS					
1.00	ADULTS & PEDIATRICS	30.00	327,991	0	1.00
	TOTALS		327,991	0	
E - CENTRAL SUPPLY					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,749,183	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	15,469	2.00
	TOTALS		0	1,764,652	
F - LAUNDRY					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	194,000	1.00
	TOTALS		0	194,000	
G - RENAL DIALYSIS CENTER					
1.00	RENAL DIALYSIS	74.00	0	741,909	1.00
	TOTALS		0	741,909	
500.00	Grand Total: Increases		823,637	3,418,845	500.00

RECLASSIFICATIONS

Provider CCN: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet A-6
Date/Time Prepared:
5/2/2022 11:40 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1.00	A - CAFETERIA						
	DIETARY	10.00	0	718,284	0		1.00
	0		0	718,284			
	B - TEACHING						
1.00	ADULTS & PEDIATRICS	30.00	31,484	0	0		1.00
2.00	OPERATING ROOM	50.00	57,765	0	0		2.00
3.00	EMERGENCY	91.00	134,276	0	0		3.00
	0		223,525	0			
	C - MEDICAL DIRECTOR						
1.00	ADMINISTRATIVE & GENERAL	5.00	272,121	0	0		1.00
	0		272,121	0			
	D - TRANSPORTERS						
1.00	ADMINISTRATIVE & GENERAL	5.00	327,991	0	0		1.00
	TOTALS		327,991	0			
	E - CENTRAL SUPPLY						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,749,183	0		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	15,469	0		2.00
	TOTALS		0	1,764,652			
	F - LAUNDRY						
1.00	HOUSEKEEPING	9.00	0	194,000	0		1.00
	TOTALS		0	194,000			
	G - RENAL DIALYSIS CENTER						
1.00	OPERATION OF PLANT	7.00	0	741,909	0		1.00
	TOTALS		0	741,909			
500.00	Grand Total: Decreases		823,637	3,418,845			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet A-7
Part I
Date/Time Prepared:
5/2/2022 11:40 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0	0	0	0	1.00	
2.00	Land Improvements	0	0	0	0	0	2.00	
3.00	Buildings and Fixtures	55,952,138	0	0	0	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	182,787	0	0	0	0	5.00	
6.00	Movable Equipment	4,559,517	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)	60,694,442	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)	60,694,442	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	0	0				1.00	
2.00	Land Improvements	0	0				2.00	
3.00	Buildings and Fixtures	55,952,138	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	182,787	0				5.00	
6.00	Movable Equipment	4,559,517	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	60,694,442	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	60,694,442	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet A-7
Part II
Date/Time Prepared:
5/2/2022 11:40 am

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	829,448	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	252,249	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,081,697	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	829,448				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	252,249				2.00
3.00	Total (sum of lines 1-2)	0	1,081,697				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet A-7
Part III
Date/Time Prepared:
5/2/2022 11:40 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	56,134,925	0	56,134,925	0.924878	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,559,517	0	4,559,517	0.075122	0	2.00
3.00	Total (sum of lines 1-2)	60,694,442	0	60,694,442	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	829,448	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	252,249	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,081,697	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,679,827	0	0	0	2,509,275	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	696,164	0	0	0	948,413	2.00
3.00	Total (sum of lines 1-2)	2,375,991	0	0	0	3,457,688	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0300

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

Worksheet A-8

Date/Time Prepared:
5/2/2022 11:40 am

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	-28	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0		0.00	0	3.00
4.00	Investment income - other (chapter 2)		0		0.00	0	4.00
5.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	5.00
6.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	6.00
7.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	7.00
8.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	8.00
9.00	Television and radio service (chapter 21)		0		0.00	0	9.00
10.00	Parking lot (chapter 21)	B	-126,324	ADMINISTRATIVE & GENERAL	5.00	0	10.00
11.00	Provider-based physician adjustment	A-8-2	-8,310,574			0	11.00
12.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	12.00
13.00	Related organization transactions (chapter 10)	A-8-1	4,058,743			0	13.00
14.00	Laundry and linen service		0		0.00	0	14.00
15.00	Cafeteria-employees and guests		0		0.00	0	15.00
16.00	Rental of quarters to employee and others		0		0.00	0	16.00
17.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	17.00
18.00	Sale of drugs to other than patients	B	-116,979	PHARMACY	15.00	0	18.00
19.00	Sale of medical records and abstracts		0		0.00	0	19.00
20.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	20.00
21.00	Vending machines		0		0.00	0	21.00
22.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	22.00
23.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	23.00
24.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		24.00
25.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		25.00
26.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		26.00
27.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	27.00
28.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	28.00
29.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		29.00
30.00	Physicians' assistant		0		0.00	0	30.00
30.99	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.99
31.00	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		31.00
32.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		32.00
	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0300

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

Worksheet A-8

Date/Time Prepared:
5/2/2022 11:40 am

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	
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
33.01	ADDED INTEREST CAPITAL	A	1,679,855	CAP REL COSTS-BLDG & FIXT	1.00	11	33.01
33.02	ADDED INTEREST MVBL EQUIP CAPITAL	A	696,164	CAP REL COSTS-MVBLE EQUIP	2.00	11	33.02
33.03	ADDED INTEREST WORKING CAPITAL	A	614,456	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	LOBBYING	A	-7,644	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	MIDLEVEL EXPENSE	A	-261,644	OPERATING ROOM	50.00	0	33.05
33.06	MIDLEVEL EXPENSE	A	-564,394	CLINIC	90.00	0	33.06
33.07	MIDLEVEL EXPENSE	A	-435,147	EMERGENCY	91.00	0	33.07
33.08	PENSION EXPENSE	A	8,952,413	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		6,178,897				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0300

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

Worksheet A-8-1

Date/Time Prepared:
5/2/2022 11:40 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	CCHHS - HUMAN RESOURCES	722,971	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	CCHHS - CAPITAL	174,234	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	CCHHS - A&G	3,052,259	0	3.00
3.01	13.00	NURSING ADMINISTRATION	CCHHS - NURSING ADMIN	64,211	0	3.01
3.02	73.00	DRUGS CHARGED TO PATIENTS	CCHHS - DRUGS	45,068	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.			4,058,743	0	5.00

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

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

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

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

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

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

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

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

Provider CCN: 14-0300

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

Worksheet A-8-1

Date/Time Prepared:
5/2/2022 11:40 am

	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	722,971	0		1.00
2.00	174,234	0		2.00
3.00	3,052,259	0		3.00
3.01	64,211	0		3.01
3.02	45,068	0		3.02
4.00	0	0		4.00
5.00	4,058,743			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0300

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

Worksheet A-8-2

Date/Time Prepared:
5/2/2022 11:40 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	223,525	0	223,525	211,500	1,529	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,488,079	940,850	547,229	179,000	3,843	2.00
3.00	50.00	OPERATING ROOM	1,724,453	1,694,253	30,200	246,400	194	3.00
4.00	53.00	ANESTHESIOLOGY	335,300	307,816	27,484	239,400	165	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	745,520	745,520	0	271,900	0	5.00
6.00	60.00	LABORATORY	217,404	152,183	65,221	260,300	602	6.00
7.00	69.00	ELECTROCARDIOLOGY	375,000	375,000	0	211,500	0	7.00
8.00	90.00	CLINIC	1,478,223	1,374,239	103,984	179,000	971	8.00
9.00	91.00	EMERGENCY	2,620,241	2,338,467	281,774	246,400	1,655	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			9,207,745	7,928,328	1,279,417		8,959	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	155,473	7,774	0	0	4,449	1.00
2.00	30.00	ADULTS & PEDIATRICS	330,720	16,536	0	0	29,620	2.00
3.00	50.00	OPERATING ROOM	22,981	1,149	0	0	34,325	3.00
4.00	53.00	ANESTHESIOLOGY	18,991	950	0	0	6,674	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	14,840	5.00
6.00	60.00	LABORATORY	75,337	3,767	0	0	4,327	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	7,464	7.00
8.00	90.00	CLINIC	83,562	4,178	0	0	29,424	8.00
9.00	91.00	EMERGENCY	196,054	9,803	0	0	52,156	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			883,118	44,157	0	0	183,279	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	4,449	159,922	63,603	63,603		1.00
2.00	30.00	ADULTS & PEDIATRICS	10,893	341,613	205,616	1,146,466		2.00
3.00	50.00	OPERATING ROOM	601	23,582	6,618	1,700,871		3.00
4.00	53.00	ANESTHESIOLOGY	547	19,538	7,946	315,762		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	745,520		5.00
6.00	60.00	LABORATORY	1,298	76,635	0	152,183		6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	375,000		7.00
8.00	90.00	CLINIC	2,070	85,632	18,352	1,392,591		8.00
9.00	91.00	EMERGENCY	5,609	201,663	80,111	2,418,578		9.00
10.00	0.00		0	0	0	0		10.00
200.00			25,467	908,585	382,246	8,310,574		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet B
Part I
Date/Time Prepared:
5/2/2022 11:40 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,509,275	2,509,275			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	948,413		948,413		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	16,800,443	25,606	0	16,826,049	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,103,356	490,550	196,941	699,670	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	8,438	22,228	0	6.00
7.00	00700	OPERATION OF PLANT	7,065,486	375,932	92,067	1,410,532	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	306,470	0	0	0	8.00
9.00	00900	HOUSEKEEPING	843,939	7,303	10,198	416,642	9.00
10.00	01000	DIETARY	0	81,142	0	0	10.00
11.00	01100	CAFETERIA	718,284	36,431	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,179,268	17,319	54,024	462,456	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	338,739	11,744	6,869	131,931	14.00
15.00	01500	PHARMACY	2,541,993	15,708	2,893	1,261,590	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	61,570	55,888	0	30,960	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	159,922	0	0	112,398	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,516,459	279,342	147,807	1,841,869	30.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,836,273	151,206	98,358	1,910,186	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	33,446	42,990	0	175,596	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,757,154	167,808	242,934	1,089,436	54.00
60.00	06000	LABORATORY	1,028,959	133,164	12,014	570,793	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	22,186	0	65.00
66.00	06600	PHYSICAL THERAPY	813,493	37,122	5,813	272,104	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	18,095	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	160,684	11,561	29,331	200,383	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,030,497	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,084,204	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,068	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	741,909	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	4,328,552	396,452	3,044	3,143,193	90.00
91.00	09100	EMERGENCY	3,303,908	145,474	1,706	3,096,310	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	69,257,764	2,509,275	948,413	16,826,049	118.00
NONREIMBURSABLE COST CENTERS							
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	69,257,764	2,509,275	948,413	16,826,049	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet B
Part I
Date/Time Prepared:
5/2/2022 11:40 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,490,517					5.00
6.00	00600	MAINTENANCE & REPAIRS	7,418	38,084				6.00
7.00	00700	OPERATION OF PLANT	2,163,602	7,214	11,114,833			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	74,138	0	0	380,608		8.00
9.00	00900	HOUSEKEEPING	309,178	140	50,457	17,699	1,655,556	9.00
10.00	01000	DIETARY	19,629	1,557	560,612	0	0	10.00
11.00	01100	CAFETERIA	182,572	699	251,699	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	656,313	332	119,655	0	274,590	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	118,361	225	81,136	319	19,593	14.00
15.00	01500	PHARMACY	924,617	301	108,527	0	13,557	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	35,904	1,072	386,130	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	65,876	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,157,645	5,360	1,929,974	235,249	669,318	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	966,670	2,902	1,044,682	35,454	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	60,969	825	297,020	86	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	787,975	3,220	1,159,381	404	67,853	54.00
60.00	06000	LABORATORY	422,113	2,555	920,027	513	25,560	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	5,367	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	273,001	712	256,474	221	7,167	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,377	347	125,016	13	2,860	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	97,237	222	79,875	74	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	733,101	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	746,094	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,902	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	179,474	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	1,904,116	7,609	2,739,086	49	0	90.00
91.00	09100	EMERGENCY	1,583,868	2,792	1,005,082	90,527	575,058	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,490,517	38,084	11,114,833	380,608	1,655,556	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	13,490,517	38,084	11,114,833	380,608	1,655,556	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet B
Part I
Date/Time Prepared:
5/2/2022 11:40 am

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	662,940					10.00
11.00	01100	CAFETERIA	0	1,189,685				11.00
13.00	01300	NURSING ADMINISTRATION	0	45,788	3,809,745			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	708,917		14.00
15.00	01500	PHARMACY	0	0	0	301	4,869,487	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	54,910	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	655,963	599,389	1,371,896	0	0	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	101,423	356,687	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	78,680	197,647	87	0	54.00
60.00	06000	LABORATORY	0	85,748	0	41	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	49,745	0	7	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,239	0	2	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	708,302	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,869,487	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	1,218,952	177	0	90.00
91.00	09100	EMERGENCY	6,977	163,763	664,563	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	662,940	1,189,685	3,809,745	708,917	4,869,487	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	662,940	1,189,685	3,809,745	708,917	4,869,487	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet B
Part I
Date/Time Prepared:
5/2/2022 11:40 am

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		Subtotal	
					SERVICES-SALAR Y & FRINGES	SERVICES-OTHER		
					APPRV	PRGM COSTS APPRV		
			16.00	17.00	21.00	22.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	626,434					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		338,196		22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	33,088	0	0	218,543	11,661,902	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,098	0	0	36,021	6,542,960	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	19,894	630,826	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	76	0	0	15,452	5,568,107	54.00
60.00	06000	LABORATORY	229	0	0	0	3,201,716	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	27,553	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	1,715,859	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	150,708	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	589,608	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	4,471,900	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,830,298	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,925,457	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	921,383	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	355,103	0	0	0	14,096,333	90.00
91.00	09100	EMERGENCY	234,840	0	0	48,286	10,923,154	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	626,434	0	0	338,196	69,257,764	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	626,434	0	0	338,196	69,257,764	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet B
Part I
Date/Time Prepared:
5/2/2022 11:40 am

Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-218,543	11,443,359	30.00
43.00	04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-36,021	6,506,939	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	-19,894	610,932	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-15,452	5,552,655	54.00
60.00	06000	LABORATORY	0	3,201,716	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	27,553	65.00
66.00	06600	PHYSICAL THERAPY	0	1,715,859	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	150,708	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	589,608	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,471,900	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,830,298	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,925,457	73.00
74.00	07400	RENAL DIALYSIS	0	921,383	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	14,096,333	90.00
91.00	09100	EMERGENCY	-48,286	10,874,868	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-338,196	68,919,568	118.00
NONREIMBURSABLE COST CENTERS					
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	-338,196	68,919,568	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet B
Part II
Date/Time Prepared:
5/2/2022 11:40 am

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	25,606	25,606	25,606	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	193,356	490,550	880,847	1,064	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	8,438	30,666	0	6.00
7.00	00700	OPERATION OF PLANT	0	375,932	92,067	2,146	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	7,303	10,198	634	9.00
10.00	01000	DIETARY	0	81,142	0	81,142	10.00
11.00	01100	CAFETERIA	0	36,431	0	36,431	11.00
13.00	01300	NURSING ADMINISTRATION	0	17,319	54,024	704	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,744	6,869	201	14.00
15.00	01500	PHARMACY	0	15,708	2,893	1,919	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	55,888	0	47	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	171	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	279,342	147,807	427,149	30.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	151,206	98,358	249,564	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	42,990	0	42,990	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	167,808	242,934	410,742	54.00
60.00	06000	LABORATORY	0	133,164	12,014	145,178	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	22,186	22,186	65.00
66.00	06600	PHYSICAL THERAPY	0	37,122	5,813	42,935	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	18,095	0	18,095	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	11,561	29,331	40,892	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	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	396,452	3,044	399,496	90.00
91.00	09100	EMERGENCY	0	145,474	1,706	147,180	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	193,356	2,509,275	948,413	3,651,044	118.00
NONREIMBURSABLE COST CENTERS							
200.00		Cross Foot Adjustments			0		200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	193,356	2,509,275	948,413	3,651,044	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet B
Part II
Date/Time Prepared:
5/2/2022 11:40 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	881,911					5.00
6.00	00600	MAINTENANCE & REPAIRS	485	31,151				6.00
7.00	00700	OPERATION OF PLANT	141,446	5,900	617,491			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,847	0	0	4,847		8.00
9.00	00900	HOUSEKEEPING	20,212	115	2,803	225	41,490	9.00
10.00	01000	DIETARY	1,283	1,274	31,145	0	0	10.00
11.00	01100	CAFETERIA	11,935	572	13,983	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	42,904	272	6,647	0	6,882	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,738	184	4,508	4	491	14.00
15.00	01500	PHARMACY	60,444	247	6,029	0	340	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,347	877	21,452	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	4,306	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	75,678	4,384	107,221	2,995	16,772	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	63,193	2,373	58,038	452	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	3,986	675	16,501	1	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	51,511	2,634	64,410	5	1,700	54.00
60.00	06000	LABORATORY	27,594	2,090	51,113	7	641	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	351	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	17,847	583	14,249	3	180	66.00
67.00	06700	OCCUPATIONAL THERAPY	286	284	6,945	0	72	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6,357	181	4,438	1	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	47,924	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	48,774	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	713	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	11,733	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	124,476	6,223	152,171	1	0	90.00
91.00	09100	EMERGENCY	103,541	2,283	55,838	1,153	14,412	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	881,911	31,151	617,491	4,847	41,490	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	881,911	31,151	617,491	4,847	41,490	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet B
Part II
Date/Time Prepared:
5/2/2022 11:40 am

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	114,844					10.00
11.00	01100	CAFETERIA	0	62,921				11.00
13.00	01300	NURSING ADMINISTRATION	0	2,422	131,174			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	31,739		14.00
15.00	01500	PHARMACY	0	0	0	13	87,593	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,904	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	113,635	31,701	47,236	0	0	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	5,364	12,281	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,161	6,805	4	0	54.00
60.00	06000	LABORATORY	0	4,535	0	2	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,631	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	542	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	31,712	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	87,593	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	41,970	8	0	90.00
91.00	09100	EMERGENCY	1,209	8,661	22,882	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	114,844	62,921	131,174	31,739	87,593	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	114,844	62,921	131,174	31,739	87,593	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0300

Period:
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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		Subtotal	
					SERVICES-SALAR Y & FRINGES	SERVICES-OTHER		
					APPRV	PRGM COSTS APPRV		
			16.00	17.00	21.00	22.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	83,515					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		4,477		22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,411	0			833,984	30.00
43.00	04300	NURSERY	0	0			0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	413	0			394,584	50.00
51.00	05100	RECOVERY ROOM	0	0			0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0			0	52.00
53.00	05300	ANESTHESIOLOGY	0	0			64,420	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10	0			543,639	54.00
60.00	06000	LABORATORY	30	0			232,058	60.00
60.01	06001	BLOOD LABORATORY	0	0			0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0			0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0			22,537	65.00
66.00	06600	PHYSICAL THERAPY	0	0			78,842	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0			25,682	67.00
68.00	06800	SPEECH PATHOLOGY	0	0			0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0			52,716	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			79,636	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0			48,774	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0			88,306	73.00
74.00	07400	RENAL DIALYSIS	0	0			11,733	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0			0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	89.00
90.00	09000	CLINIC	47,343	0			776,478	90.00
91.00	09100	EMERGENCY	31,308	0			393,178	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0			0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0			0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0			0	110.00
111.00	11100	ISLET ACQUISITION	0	0			0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	83,515	0	0	0	3,646,567	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments			0	4,477	4,477	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	83,515	0	0	4,477	3,651,044	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet B
Part II
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5/2/2022 11:40 am

Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	833,984	30.00
43.00	04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	394,584	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	64,420	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	543,639	54.00
60.00	06000	LABORATORY	0	232,058	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	22,537	65.00
66.00	06600	PHYSICAL THERAPY	0	78,842	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	25,682	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	52,716	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	79,636	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	48,774	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	88,306	73.00
74.00	07400	RENAL DIALYSIS	0	11,733	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	776,478	90.00
91.00	09100	EMERGENCY	0	393,178	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,646,567	118.00
NONREIMBURSABLE COST CENTERS					
200.00		Cross Foot Adjustments	0	4,477	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	3,651,044	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0300

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

Worksheet B-1

Date/Time Prepared:
5/2/2022 11:40 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	384,823					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		319,629				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,927	0	33,461,991			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	75,231	66,372	1,391,433	-13,490,517	55,767,247	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,294	7,491	0	0	30,666	6.00
7.00	00700	OPERATION OF PLANT	57,653	31,028	2,805,126	0	8,944,017	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	306,470	8.00
9.00	00900	HOUSEKEEPING	1,120	3,437	828,576	0	1,278,082	9.00
10.00	01000	DIETARY	12,444	0	0	0	81,142	10.00
11.00	01100	CAFETERIA	5,587	0	0	0	754,715	11.00
13.00	01300	NURSING ADMINISTRATION	2,656	18,207	919,687	0	2,713,067	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,801	2,315	262,371	0	489,283	14.00
15.00	01500	PHARMACY	2,409	975	2,508,925	0	3,822,184	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,571	0	61,570	0	148,418	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	223,525	0	272,320	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	42,840	49,813	3,662,925	0	4,785,477	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	23,189	33,148	3,798,788	0	3,996,023	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	6,593	0	349,208	0	252,032	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,735	81,872	2,166,561	0	3,257,332	54.00
60.00	06000	LABORATORY	20,422	4,049	1,135,136	0	1,744,930	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	7,477	0	0	22,186	65.00
66.00	06600	PHYSICAL THERAPY	5,693	1,959	541,134	0	1,128,532	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,775	0	0	0	18,095	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,773	9,885	398,502	0	401,959	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	3,030,497	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,084,204	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	45,068	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	741,909	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	60,800	1,026	6,250,891	0	7,871,241	90.00
91.00	09100	EMERGENCY	22,310	575	6,157,633	0	6,547,398	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	384,823	319,629	33,461,991	-13,490,517	55,767,247	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,509,275	948,413	16,826,049		13,490,517	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.520595	2.967231	0.502841		0.241908	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			25,606		881,911	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000765		0.015814	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0300

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

Worksheet B-1

Date/Time Prepared:
5/2/2022 11:40 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	304,371				6.00
7.00	00700	OPERATION OF PLANT	57,653	246,718			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	486,312		8.00
9.00	00900	HOUSEKEEPING	1,120	1,120	22,614	46,895	9.00
10.00	01000	DIETARY	12,444	12,444	0	0	11,782 10.00
11.00	01100	CAFETERIA	5,587	5,587	0	0	0 11.00
13.00	01300	NURSING ADMINISTRATION	2,656	2,656	0	7,778	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,801	1,801	407	555	0 14.00
15.00	01500	PHARMACY	2,409	2,409	0	384	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,571	8,571	0	0	0 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0 17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0 22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	42,840	42,840	300,588	18,959	11,658 30.00
43.00	04300	NURSERY	0	0	0	0	0 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	23,189	23,189	45,300	0	0 50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	6,593	6,593	110	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,735	25,735	516	1,922	0 54.00
60.00	06000	LABORATORY	20,422	20,422	655	724	0 60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0 60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0 62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	5,693	5,693	282	203	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	2,775	2,775	16	81	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	1,773	1,773	94	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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	0	0	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0 74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
90.00	09000	CLINIC	60,800	60,800	62	0	0 90.00
91.00	09100	EMERGENCY	22,310	22,310	115,668	16,289	124 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0 99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0 109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0 111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	304,371	246,718	486,312	46,895	11,782 118.00
NONREIMBURSABLE COST CENTERS							
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	38,084	11,114,833	380,608	1,655,556	662,940 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.125124	45.050758	0.782642	35.303465	56.267187 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	31,151	617,491	4,847	41,490	114,844 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.102345	2.502821	0.009967	0.884743	9.747411 205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0300

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

Worksheet B-1

Date/Time Prepared:
5/2/2022 11:40 am

Cost Center Description			CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	39,389					11.00
13.00	01300	NURSING ADMINISTRATION	1,516	136,278				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,299,357			14.00
15.00	01500	PHARMACY	0	0	551	3,020,231		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,818	0	0	0	24,669	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	19,845	49,074	0	0	1,303	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,358	12,759	0	0	122	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,605	7,070	159	0	3	54.00
60.00	06000	LABORATORY	2,839	0	75	0	9	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,647	0	12	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	339	0	4	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,298,231	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,020,231	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	43,603	325	0	13,984	90.00
91.00	09100	EMERGENCY	5,422	23,772	0	0	9,248	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	39,389	136,278	1,299,357	3,020,231	24,669	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,189,685	3,809,745	708,917	4,869,487	626,434	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	30.203483	27.955686	0.545591	1.612290	25.393571	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	62,921	131,174	31,739	87,593	83,515	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.597426	0.962547	0.024427	0.029002	3.385423	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0300

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

Worksheet B-1

Date/Time Prepared:
5/2/2022 11:40 am

Cost Center Description			INTERNS & RESIDENTS			
			SOCIAL SERVICE (TIME SPENT)	SERVICES-SALAR	SERVICES-OTHER	
				Y & FRINGES	PRGM COSTS	
				APPRV (ASSIGNED TIME)	APPRV (ASSIGNED TIME)	
17.00			21.00	22.00		
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	0			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		3,502	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	2,263	30.00
43.00	04300	NURSERY	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	373	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	206	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	160	54.00
60.00	06000	LABORATORY	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
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	0	0	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	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	500	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	3,502	118.00
NONREIMBURSABLE COST CENTERS						
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	0	338,196	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	96.572244	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	4,477	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	1.278412	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

Worksheet C
Part I
Date/Time Prepared:
5/2/2022 11:40 am

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COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet C
Part I
Date/Time Prepared:
5/2/2022 11:40 am

			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	3,334,164		3,334,164			30.00
43.00	04300	NURSERY	0		0			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	144,469	17,089,538	17,234,007	0.377564	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	12,640	2,741,744	2,754,384	0.221803	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	375,051	10,426,631	10,801,682	0.514055	0.000000	54.00
60.00	06000	LABORATORY	511,771	12,213,124	12,724,895	0.251610	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0.000000	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	153,900	340,655	494,555	0.055713	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	11,960	1,348	13,308	128.934400	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	592	0	592	254.574324	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	207,753	1,722,888	1,930,641	0.305395	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,659	1,061,194	1,066,853	4.191674	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	150	766,400	766,550	4.996801	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	771,715	4,243,472	5,015,187	0.982108	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	2,676	2,676	344.313528	0.000000	74.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	1,981	12,858,424	12,860,405	1.096103	0.000000	90.00
91.00	09100	EMERGENCY	299,439	11,449,834	11,749,273	0.925578	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	595,824	3,442,305	4,038,129	1.042842	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0			99.10
	SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
200.00		Subtotal (see instructions)	6,427,068	78,360,233	84,787,301			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,427,068	78,360,233	84,787,301			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet C
Part I
Date/Time Prepared:
5/2/2022 11:40 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.377948			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	0.224688			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.514055			54.00
60.00	06000 LABORATORY	0.251610			60.00
60.01	06001 BLOOD LABORATORY	0.000000			60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000			62.00
65.00	06500 RESPIRATORY THERAPY	0.055713			65.00
66.00	06600 PHYSICAL THERAPY	128.934400			66.00
67.00	06700 OCCUPATIONAL THERAPY	254.574324			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.305395			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4.191674			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	4.996801			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.982108			73.00
74.00	07400 RENAL DIALYSIS	344.313528			74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000 CLINIC	1.097530			90.00
91.00	09100 EMERGENCY	0.932396			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.042842			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910 CORF				99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900 PANCREAS ACQUISITION				109.00
110.00	11000 INTESTINAL ACQUISITION				110.00
111.00	11100 ISLET ACQUISITION				111.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet C
Part I
Date/Time Prepared:
5/2/2022 11:40 am

			Title XIX	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Total Costs
			1.00	2.00	3.00	4.00
						5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,443,359		11,443,359	205,616
43.00	04300	NURSERY	0		0	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,506,939		6,506,939	6,618
51.00	05100	RECOVERY ROOM	0		0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0
53.00	05300	ANESTHESIOLOGY	610,932		610,932	7,946
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,552,655		5,552,655	0
60.00	06000	LABORATORY	3,201,716		3,201,716	0
60.01	06001	BLOOD LABORATORY	0		0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0		0	0
65.00	06500	RESPIRATORY THERAPY	27,553	0	27,553	0
66.00	06600	PHYSICAL THERAPY	1,715,859	0	1,715,859	0
67.00	06700	OCCUPATIONAL THERAPY	150,708	0	150,708	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	589,608		589,608	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,471,900		4,471,900	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,830,298		3,830,298	0
73.00	07300	DRUGS CHARGED TO PATIENTS	4,925,457		4,925,457	0
74.00	07400	RENAL DIALYSIS	921,383		921,383	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0
90.00	09000	CLINIC	14,096,333		14,096,333	18,352
91.00	09100	EMERGENCY	10,874,868		10,874,868	80,111
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,211,130		4,211,130	0
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0	0
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0		0	0
110.00	11000	INTESTINAL ACQUISITION	0		0	0
111.00	11100	ISLET ACQUISITION	0		0	0
200.00		Subtotal (see instructions)	73,130,698	0	73,130,698	318,643
201.00		Less Observation Beds	4,211,130		4,211,130	0
202.00		Total (see instructions)	68,919,568	0	68,919,568	318,643

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet C
Part I
Date/Time Prepared:
5/2/2022 11:40 am

			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	3,334,164		3,334,164		30.00
43.00	04300	NURSERY	0		0		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	144,469	17,089,538	17,234,007	0.377564	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	12,640	2,741,744	2,754,384	0.221803	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	375,051	10,426,631	10,801,682	0.514055	54.00
60.00	06000	LABORATORY	511,771	12,213,124	12,724,895	0.251610	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	153,900	340,655	494,555	0.055713	65.00
66.00	06600	PHYSICAL THERAPY	11,960	1,348	13,308	128.934400	66.00
67.00	06700	OCCUPATIONAL THERAPY	592	0	592	254.574324	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	207,753	1,722,888	1,930,641	0.305395	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,659	1,061,194	1,066,853	4.191674	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	150	766,400	766,550	4.996801	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	771,715	4,243,472	5,015,187	0.982108	73.00
74.00	07400	RENAL DIALYSIS	0	2,676	2,676	344.313528	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
90.00	09000	CLINIC	1,981	12,858,424	12,860,405	1.096103	90.00
91.00	09100	EMERGENCY	299,439	11,449,834	11,749,273	0.925578	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	595,824	3,442,305	4,038,129	1.042842	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
200.00		Subtotal (see instructions)	6,427,068	78,360,233	84,787,301		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	6,427,068	78,360,233	84,787,301		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet C
Part I
Date/Time Prepared:
5/2/2022 11:40 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000	LABORATORY	0.000000			60.00
60.01	06001	BLOOD LABORATORY	0.000000			60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD 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						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION				109.00
110.00	11000	INTESTINAL ACQUISITION				110.00
111.00	11100	ISLET ACQUISITION				111.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet D
Part I
Date/Time Prepared:
5/2/2022 11:40 am

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Hospital Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		833,984	0	833,984	2,556	326.28	30.00
43.00	NURSERY		0		0	0	0.00	43.00
200.00	Total (lines 30 through 199)		833,984		833,984	2,556		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		168	54,815				
43.00	NURSERY		0	0				
200.00	Total (lines 30 through 199)		168	54,815				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet D
Part II
Date/Time Prepared:
5/2/2022 11:40 am

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	394,584	17,234,007	0.022896	1,699	39 50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0 52.00
53.00	05300	ANESTHESIOLOGY	64,420	2,754,384	0.023388	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	543,639	10,801,682	0.050329	41,987	2,113 54.00
60.00	06000	LABORATORY	232,058	12,724,895	0.018237	63,823	1,164 60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0 60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0.000000	0	0 62.00
65.00	06500	RESPIRATORY THERAPY	22,537	494,555	0.045570	31,291	1,426 65.00
66.00	06600	PHYSICAL THERAPY	78,842	13,308	5.924406	3,724	22,062 66.00
67.00	06700	OCCUPATIONAL THERAPY	25,682	592	43.381757	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	52,716	1,930,641	0.027305	35,530	970 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	79,636	1,066,853	0.074646	5,659	422 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	48,774	766,550	0.063628	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	88,306	5,015,187	0.017608	98,055	1,727 73.00
74.00	07400	RENAL DIALYSIS	11,733	2,676	4.384529	0	0 74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0 89.00
90.00	09000	CLINIC	776,478	12,860,405	0.060377	0	0 90.00
91.00	09100	EMERGENCY	393,178	11,749,273	0.033464	27,517	921 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	301,487	4,038,129	0.074660	53,840	4,020 92.00
200.00		Total (lines 50 through 199)	3,114,070	81,453,137		363,125	34,864 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0300		Period: From 12/01/2020 To 11/30/2021		Worksheet D Part III Date/Time Prepared: 5/2/2022 11:40 am		
					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	
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	2,556	0.00		168	30.00	
43.00	04300	NURSERY			0	0	0.00		0	43.00	
200.00		Total (lines 30 through 199)			0	2,556			168	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	
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: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet D
Part IV
Date/Time Prepared:
5/2/2022 11:40 am

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	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0300

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

Worksheet D
Part IV
Date/Time Prepared:
5/2/2022 11:40 am

			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	17,234,007	0.000000
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	2,754,384	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	10,801,682	0.000000
60.00	06000	LABORATORY	0	0	0	12,724,895	0.000000
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	494,555	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	13,308	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	592	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,930,641	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,066,853	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	766,550	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,015,187	0.000000
74.00	07400	RENAL DIALYSIS	0	0	0	2,676	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000
90.00	09000	CLINIC	0	0	0	12,860,405	0.000000
91.00	09100	EMERGENCY	0	0	0	11,749,273	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,038,129	0.000000
200.00		Total (lines 50 through 199)	0	0	0	81,453,137	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0300

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

Worksheet D
Part IV
Date/Time Prepared:
5/2/2022 11:40 am

Cost Center Description		Title XVIII			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	1,699	0	838,311	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	39,817	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	41,987	0	704,461	0	54.00
60.00	06000	LABORATORY	0.000000	63,823	0	224,502	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	31,291	0	1,595	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	3,724	0	1,348	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	35,530	0	163,594	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	5,659	0	223,221	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	98,055	0	131,716	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	27,517	0	1,322,562	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	53,840	0	407,462	0	92.00
200.00		Total (lines 50 through 199)		363,125	0	4,058,589	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet D
Part V
Date/Time Prepared:
5/2/2022 11:40 am

			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	0.377564	838,311	0	0	316,516	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.221803	39,817	0	0	8,832	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.514055	704,461	0	0	362,132	54.00
60.00	06000	LABORATORY	0.251610	224,502	0	0	56,487	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.055713	1,595	0	0	89	65.00
66.00	06600	PHYSICAL THERAPY	128.934400	1,348	0	0	173,804	66.00
67.00	06700	OCCUPATIONAL THERAPY	254.574324	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.305395	163,594	0	0	49,961	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4.191674	223,221	0	0	935,670	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4.996801	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.982108	131,716	778	30,264	129,359	73.00
74.00	07400	RENAL DIALYSIS	344.313528	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000	CLINIC	1.096103	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.925578	1,322,562	0	0	1,224,134	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.042842	407,462	0	0	424,918	92.00
200.00		Subtotal (see instructions)		4,058,589	778	30,264	3,681,902	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		4,058,589	778	30,264	3,681,902	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet D
Part V
Date/Time Prepared:
5/2/2022 11:40 am

			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD 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	764	29,723		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000	CLINIC	0	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)	764	29,723		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	764	29,723		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet D
Part V
Date/Time Prepared:
5/2/2022 11:40 am

			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	0.377564	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.221803	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.514055	0	0	0	0	54.00
60.00	06000	LABORATORY	0.251610	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.055713	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	128.934400	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	254.574324	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.305395	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4.191674	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4.996801	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.982108	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	344.313528	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC						88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000	CLINIC	1.096103	2,424,498	0	0	2,657,500	90.00
91.00	09100	EMERGENCY	0.925578	6,197,933	0	0	5,736,670	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.042842	1,662,609	0	0	1,733,838	92.00
200.00		Subtotal (see instructions)		10,285,040	0	0	10,128,008	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		10,285,040	0	0	10,128,008	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet D
Part V
Date/Time Prepared:
5/2/2022 11:40 am

			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	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0300	Period: From 12/01/2020 To 11/30/2021	Worksheet D-1 Date/Time Prepared: 5/2/2022 11:40 am	
		Title XVIII	Hospital	PPS	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			2,556	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,556	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)			1,632	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)			168	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)			11,648,975	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)			11,648,975	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)			11,648,975	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)			4,557.50	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			765,660	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)			765,660	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0300

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

Worksheet D-1

Date/Time Prepared:
5/2/2022 11:40 am

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospital Program Days	Program Cost (col. 3 x col. 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					732,857	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,498,517	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)					54,815	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					34,864	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					89,679	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,408,838	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)					924	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					4,557.50	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					4,211,130	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0300

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

Worksheet D-1

Date/Time Prepared:
5/2/2022 11:40 am

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	833,984	11,648,975	0.071593	4,211,130	301,487	90.00
91.00 Nursing Program cost	0	11,648,975	0.000000	4,211,130	0	91.00
92.00 Allied health cost	0	11,648,975	0.000000	4,211,130	0	92.00
93.00 All other Medical Education	0	11,648,975	0.000000	4,211,130	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0300	Period: From 12/01/2020 To 11/30/2021	Worksheet D-3 Date/Time Prepared: 5/2/2022 11:40 am
			Title XVIII	Hospital	PPS
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		510,172	
43.00	04300	NURSERY			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.377948	1,699	642
51.00	05100	RECOVERY ROOM	0.000000	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0
53.00	05300	ANESTHESIOLOGY	0.224688	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.514055	41,987	21,584
60.00	06000	LABORATORY	0.251610	63,823	16,059
60.01	06001	BLOOD LABORATORY	0.000000	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0
65.00	06500	RESPIRATORY THERAPY	0.055713	31,291	1,743
66.00	06600	PHYSICAL THERAPY	128.934400	3,724	480,152
67.00	06700	OCCUPATIONAL THERAPY	254.574324	0	0
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0
69.00	06900	ELECTROCARDIOLOGY	0.305395	35,530	10,851
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4.191674	5,659	23,721
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4.996801	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.982108	98,055	96,301
74.00	07400	RENAL DIALYSIS	344.313528	0	0
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0
90.00	09000	CLINIC	1.097530	0	0
91.00	09100	EMERGENCY	0.932396	27,517	25,657
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.042842	53,840	56,147
200.00		Total (sum of lines 50 through 94 and 96 through 98)		363,125	732,857
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0
202.00		Net charges (line 200 minus line 201)		363,125	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0300	Period: From 12/01/2020 To 11/30/2021	Worksheet D-3 Date/Time Prepared: 5/2/2022 11:40 am
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		848,489	30.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.377564	30,501	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.221803	1,840	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.514055	163,320	54.00
60.00	06000	LABORATORY	0.251610	212,980	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.055713	76,637	65.00
66.00	06600	PHYSICAL THERAPY	128.934400	2,958	66.00
67.00	06700	OCCUPATIONAL THERAPY	254.574324	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.305395	68,620	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4.191674	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4.996801	57	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.982108	294,180	73.00
74.00	07400	RENAL DIALYSIS	344.313528	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	1.096103	0	90.00
91.00	09100	EMERGENCY	0.925578	19,440	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.042842	232,125	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,102,658	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)		1,102,658	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0300	Period: From 12/01/2020 To 11/30/2021	Worksheet E Part A Date/Time Prepared: 5/2/2022 11:40 am
		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)		301,493	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		60,299	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		0	2.04
3.00	Managed Care Simulated Payments		190,133	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		22.47	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		11.59	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		11.59	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		1.98	10.00
11.00	FTE count for residents in dental and podiatric programs.		4.04	11.00
12.00	Current year allowable FTE (see instructions)		6.02	12.00
13.00	Total allowable FTE count for the prior year.		6.48	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.		4.08	14.00
15.00	Sum of lines 12 through 14 divided by 3.		5.53	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		5.53	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.246106	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.186636	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.186636	21.00
22.00	IME payment adjustment (see instructions)		35,050	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		18,420	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)		-9.61	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)		35,050	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		18,420	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		10.19	30.00
31.00	Percentage of Medicaid patient days (see instructions)		26.04	31.00
32.00	Sum of lines 30 and 31		36.23	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.00	33.00
34.00	Disproportionate share adjustment (see instructions)		10,854	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0300	Period: From 12/01/2020 To 11/30/2021	Worksheet E Part A Date/Time Prepared: 5/2/2022 11:40 am	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	5,330,723	8,429,642		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	4,439,837	1,408,787		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	5,848,624			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)	6,256,320			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		0		48.00
			Amount		
			1.00		
49.00	Total payment for inpatient operating costs (see instructions)		6,274,740		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		39,901		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).		25,007		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
54.01	Islet isolation add-on payment		0		54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		6,339,648		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		6,339,648		61.00
62.00	Deductibles billed to program beneficiaries		70,928		62.00
63.00	Coinsurance billed to program beneficiaries		0		63.00
64.00	Allowable bad debts (see instructions)		40,767		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		26,499		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)		6,295,219		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0		70.50
70.87	Demonstration payment adjustment amount before sequestration		0		70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0		70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		0		70.93
70.94	HRR adjustment amount (see instructions)		0		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0300	Period: From 12/01/2020 To 11/30/2021	Worksheet E Part A Date/Time Prepared: 5/2/2022 11:40 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		6,295,219	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		4,618,137	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)		1,677,082	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	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: 14-0300	Period: From 12/01/2020 To 11/30/2021	Worksheet E Part B Date/Time Prepared: 5/2/2022 11:40 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		30,487	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		3,681,902	2.00
3.00	OPPS payments		1,859,585	3.00
4.00	Outlier payment (see instructions)		68,198	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		30,487	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		31,042	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)		31,042	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)		31,042	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		555	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)		30,487	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		1,927,783	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)		441,989	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		1,516,281	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		61,951	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		1,578,232	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,578,232	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)		69,908	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		45,440	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		1,623,672	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		1,623,672	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		1,570,694	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)		52,978	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet E-1
Part I
Date/Time Prepared:
5/2/2022 11:40 am

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,608,118		1,549,197	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	08/04/2021	10,019	08/04/2021	21,497	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		10,019		21,497	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,618,137		1,570,694	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		1,677,082		52,978	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		6,295,219		1,623,672	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0300	Period: From 12/01/2020 To 11/30/2021	Worksheet E-1 Part II Date/Time Prepared: 5/2/2022 11:40 am
		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

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0300		Period: From 12/01/2020 To 11/30/2021	Worksheet E-4 Date/Time Prepared: 5/2/2022 11:40 am	
		Title XVIII		Hospital		PPS
						1.00
COMPUTATION OF TOTAL DIRECT GME AMOUNT						
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.					0.00 1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)					11.59 2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA					0.00 3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)					0.00 3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))					0.00 4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)					0.00 4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)					0.00 4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)					11.59 5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)					1.98 6.00
7.00	Enter the lesser of line 5 or line 6					1.98 7.00
		Primary Care	Other	Total		
		1.00	2.00	3.00		
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.30	1.54	1.84		8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.30	1.54	1.84		9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		4.04			10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		4.04			10.01
11.00	Total weighted FTE count	0.30	5.58			11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	6.20			12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	2.91			13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.10	4.90			14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00			15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00			15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00			16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00			16.01
17.00	Adjusted rolling average FTE count	0.10	4.90			17.00
18.00	Per resident amount	134,233.54	114,222.96			18.00
19.00	Approved amount for resident costs	13,423	559,693	573,116		19.00
				1.00		
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00		20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00		21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00		22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00		23.00
24.00	Multiply line 22 time line 23			0		24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			573,116		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)	168	7	76	26.00	
27.00	Total Inpatient Days (see instructions)	1,632	1,632	1,632	27.00	
28.00	Ratio of inpatient days to total inpatient days	0.102941	0.004289	0.046569	28.00	
29.00	Program direct GME amount	58,997	2,458	26,689	88,144	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		100	1,086	1,186	30.00
31.00	Net Program direct GME amount				86,958	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0300	Period: From 12/01/2020 To 11/30/2021	Worksheet E-4 Date/Time Prepared: 5/2/2022 11:40 am	
		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)		2,676		33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000		34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0		35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0		36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)		1,498,517		37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0		38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0		39.00
40.00	Primary payer payments (see instructions)		0		40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		1,498,517		41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)		3,712,389		42.00
43.00	Primary payer payments (see instructions)		0		43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		3,712,389		44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		5,210,906		45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.287573		46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.712427		47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)		86,958		48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		25,007		49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		61,951		50.00

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

Provider CCN: 14-0300

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

Worksheet G

Date/Time Prepared:
5/2/2022 11:40 am

	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	403,373,508	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	-192,254,612	0	0	0	4.00
5.00 Other receivable	-50,147	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00 Inventory	559,727	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)	211,628,476	0	0	0	11.00
FIXED ASSETS					
12.00 Land	0	0	0	0	12.00
13.00 Land improvements	0	0	0	0	13.00
14.00 Accumulated depreciation	0	0	0	0	14.00
15.00 Buildings	57,726,841	0	0	0	15.00
16.00 Accumulated depreciation	-38,147,796	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	3,086,273	0	0	0	19.00
20.00 Accumulated depreciation	-161,744	0	0	0	20.00
21.00 Automobiles and trucks	0	0	0	0	21.00
22.00 Accumulated depreciation	0	0	0	0	22.00
23.00 Major movable equipment	5,559,283	0	0	0	23.00
24.00 Accumulated depreciation	-3,128,169	0	0	0	24.00
25.00 Minor equipment depreciable	-93,189	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)	24,841,499	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)	236,469,975	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	4,026,644	0	0	0	37.00
38.00 Salaries, wages, and fees payable	1,484,524	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	-588,712	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	5,227,245	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	10,149,701	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	2,519,869	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	2,519,869	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	12,669,570	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	223,800,406	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)	223,800,406	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	236,469,976	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0300

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

Worksheet G-1

Date/Time Prepared:
5/2/2022 11:40 am

		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		302,967,382		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-79,166,976				2.00
3.00	Total (sum of line 1 and line 2)		223,800,406		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		223,800,406		0		11.00
12.00	REDUCTION	-16,088,109		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)		-16,088,109		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		239,888,515		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			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	REDUCTION		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
5/2/2022 11:40 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,334,164		3,334,164	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)	3,334,164		3,334,164	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,334,164		3,334,164	17.00
18.00	Ancillary services	2,195,660	50,609,670	52,805,330	18.00
19.00	Outpatient services	897,244	27,750,563	28,647,807	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,427,068	78,360,233	84,787,301	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		63,078,867		29.00
30.00	ADJUST EXPENSES	1,093,828			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)		1,093,828		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)		64,172,695		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0300

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

Worksheet G-3

Date/Time Prepared:
5/2/2022 11:40 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	84,787,301	1.00
2.00	Less contractual allowances and discounts on patients' accounts	101,532,864	2.00
3.00	Net patient revenues (line 1 minus line 2)	-16,745,563	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	64,172,695	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-80,918,258	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	PROPERTY TAXES	-23,449	24.00
24.01	INTEREST INCOME	28	24.01
24.02	CAPITAL CONTRIBUTIONS - CURRENT	1,774,703	24.02
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	1,751,282	25.00
26.00	Total (line 5 plus line 25)	-79,166,976	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-79,166,976	29.00

ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

Provider CCN: 14-0300

Period:

Worksheet I-1

Component CCN: 14-3531

From 12/01/2020
To 11/30/2021Date/Time Prepared:
5/2/2022 11:40 am

		Renal Dialysis			
		Total Costs	Basis	Statistics	FTEs per 2080 Hours
		1.00	2.00	3.00	4.00
1.00	REGISTERED NURSES	54,331	HOURS OF SERVICE	973.00	0.47 1.00
2.00	LICENSED PRACTICAL NURSES	0	HOURS OF SERVICE	0.00	0.00 2.00
3.00	NURSES AIDES	0	HOURS OF SERVICE	0.00	0.00 3.00
4.00	TECHNICIANS	108,868	HOURS OF SERVICE	2,920.00	1.40 4.00
5.00	SOCIAL WORKERS	38,478	HOURS OF SERVICE	973.00	0.47 5.00
6.00	DIETICIANS	30,587	HOURS OF SERVICE	973.00	0.47 6.00
7.00	PHYSICIANS	27,017	ACCUMULATED COST		7.00
8.00	NON-PATIENT CARE SALARY	82,702	ACCUMULATED COST		8.00
9.00	SUBTOTAL (SUM OF LINES 1-8)	341,983			9.00
10.00	EMPLOYEE BENEFITS	222,813	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	116,075	REQUISITIONS		14.00
15.00	DRUGS	0	REQUISITIONS		15.00
16.00	OTHER	61,038	ACCUMULATED COST		16.00
17.00	SUBTOTAL (SUM OF LINES 9-16)*	741,909			17.00
18.00	CAPITAL RELATED COSTS-BLDGS. & FIXTURES	0	SQUARE FEET		18.00
19.00	CAPITAL RELATED COSTS-MOV. EQUIP.	0	PERCENTAGE OF TIME		19.00
20.00	EMPLOYEE BENEFITS DEPARTMENT	0	SALARY		20.00
21.00	ADMINISTRATIVE & GENERAL	179,474	ACCUMULATED COST		21.00
22.00	MAINT./REPAIRS-OPER-HOUSEKEEPING	0	SQUARE FEET		22.00
23.00	MEDICAL EDUCATION PROGRAM COSTS	0			23.00
24.00	CENTRAL SERVICE & SUPPLIES	0	REQUISITIONS		24.00
25.00	PHARMACY	0	REQUISITIONS		25.00
26.00	OTHER ALLOCATED COSTS	0	ACCUMULATED COST		26.00
27.00	SUBTOTAL (SUM OF LINES 17-26)*	921,383			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)	921,383			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: 14-0300

Period:

Worksheet I-2

Component CCN: 14-3531

From 12/01/2020
To 11/30/2021Date/Time Prepared:
5/2/2022 11:40 am

		Capital Related Costs		Direct Patient Care Salary		Employee Benefits Department	Drugs	
		Building	Equipment	RNs	Other			
		1.00	2.00	3.00	4.00	5.00	6.00	
1.00	Total Renal Department Costs	0	0	54,331	177,933	222,813	0	1.00
MAINTENANCE								
2.00	Hemodialysis	0	0	54,331	177,933	222,813	0	2.00
2.01	AKI-Hemodialysis	0	0	0	0	0	0	2.01
3.00	Intermittent Peritoneal	0	0	0	0	0	0	3.00
3.01	AKI-Intermittent Peritoneal	0	0	0	0	0	0	3.01
TRAINING								
4.00	Hemodialysis	0	0	0	0	0	0	4.00
5.00	Intermittent Peritoneal	0	0	0	0	0	0	5.00
6.00	CAPD	0	0	0	0	0	0	6.00
7.00	CCPD	0	0	0	0	0	0	7.00
HOME								
8.00	Hemodialysis	0	0	0	0	0	0	8.00
9.00	Intermittent Peritoneal	0	0	0	0	0	0	9.00
10.00	CAPD	0	0	0	0	0	0	10.00
11.00	CCPD	0	0	0	0	0	0	11.00
OTHER BILLABLE SERVICES								
12.00	Inpatient Dialysis	0	0	0	0	0	0	12.00
13.00	Method II Home Patient	0	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	0	16.00
17.00	Total (sum of lines 2 through 16)	0	0	54,331	177,933	222,813	0	17.00
18.00	Medical Educational Program Costs							18.00
19.00	Total Renal Costs (line 17 + line 18)							19.00
		Medical Supplies	Routine Ancillary Services	Subtotal (sum of cols. 1-8)	Overhead	Total (col. 9 + col. 10)		
		7.00	8.00	9.00	10.00	11.00		
1.00	Total Renal Department Costs	116,075	0	571,152	350,231	921,383		1.00
MAINTENANCE								
2.00	Hemodialysis	116,075	0	571,152	350,231	921,383		2.00
2.01	AKI-Hemodialysis	0	0	0	0	0		2.01
3.00	Intermittent Peritoneal	0	0	0	0	0		3.00
3.01	AKI-Intermittent Peritoneal	0	0	0	0	0		3.01
TRAINING								
4.00	Hemodialysis	0	0	0	0	0		4.00
5.00	Intermittent Peritoneal	0	0	0	0	0		5.00
6.00	CAPD	0	0	0	0	0		6.00
7.00	CCPD	0	0	0	0	0		7.00
HOME								
8.00	Hemodialysis	0	0	0	0	0		8.00
9.00	Intermittent Peritoneal	0	0	0	0	0		9.00
10.00	CAPD	0	0	0	0	0		10.00
11.00	CCPD	0	0	0	0	0		11.00
OTHER BILLABLE SERVICES								
12.00	Inpatient Dialysis	0	0	0	0	0		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)	116,075	0	571,152	350,231	921,383		17.00
18.00	Medical Educational Program Costs					0		18.00
19.00	Total Renal Costs (line 17 + line 18)					921,383		19.00

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0300

Period:

Worksheet I-3

Component CCN: 14-3531

From 12/01/2020
To 11/30/2021Date/Time Prepared:
5/2/2022 11:40 am

		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	0	0	54,331	177,933	222,813	1.00
MAINTENANCE							
2.00	Hemodialysis	1,063	1,063.00	1,063.00	1,063.00	1,063	2.00
2.01	AKI-Hemodialysis	0	0.00	0.00	0.00	0	2.01
3.00	Intermittent Peritoneal	0	0.00	0.00	0.00	0	3.00
3.01	AKI-Intermittent Peritoneal	0	0.00	0.00	0.00	0	3.01
TRAINING							
4.00	Hemodialysis	0	0.00	0.00	0.00	0	4.00
5.00	Intermittent Peritoneal	0	0.00	0.00	0.00	0	5.00
6.00	CAPD	0	0.00	0.00	0.00	0	6.00
7.00	CCPD	0	0.00	0.00	0.00	0	7.00
HOME							
8.00	Hemodialysis	0	0.00	0.00	0.00	0	8.00
9.00	Intermittent Peritoneal	0	0.00	0.00	0.00	0	9.00
10.00	CAPD	0	0.00	0.00	0.00	0	10.00
11.00	CCPD	0	0.00	0.00	0.00	0	11.00
OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis Treatments	0	0.00	0.00	0.00	0	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	1,063	1,063.00	1,063.00	1,063.00	1,063	17.00
18.00	Unit Cost Multiplier (line 1 ÷ line 17)	0.000000	0.000000	51.111007	167.387582	209.607714	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	116,075	0	571,152	350,231	1.00
MAINTENANCE							
2.00	Hemodialysis	1,063	1,063	1,063			2.00
2.01	AKI-Hemodialysis	0	0	0			2.01
3.00	Intermittent Peritoneal	0	0	0			3.00
3.01	AKI-Intermittent Peritoneal	0	0	0			3.01
TRAINING							
4.00	Hemodialysis	0	0	0			4.00
5.00	Intermittent Peritoneal	0	0	0			5.00
6.00	CAPD	0	0	0			6.00
7.00	CCPD	0	0	0			7.00
HOME							
8.00	Hemodialysis	0	0	0			8.00
9.00	Intermittent Peritoneal	0	0	0			9.00
10.00	CAPD	0	0	0			10.00
11.00	CCPD	0	0	0			11.00
OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis Treatments	0	0	0			12.00
13.00	Method II Home Patient	0	0	0			13.00
14.00	ESAs						14.00
15.00							15.00
16.00	Other	0	0	0			16.00
17.00	Total Statistical Basis	1,063	1,063	1,063		571,152	17.00
18.00	Unit Cost Multiplier (line 1 ÷ line 17)	0.000000	109.195673	0.000000		0.613201	18.00

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

Provider CCN: 14-0300

Period:

Worksheet I-4

Component CCN: 14-3531

From 12/01/2020
To 11/30/2021Date/Time Prepared:
5/2/2022 11:40 am

		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	1,063	921,383	866.78	316	273,902
2.00	Maintenance - Peritoneal Dialysis	0	0	0.00	0	0
3.00	Training - Hemodialysis	0	0	0.00	0	0
4.00	Training - Peritoneal Dialysis	0	0	0.00	0	0
5.00	Training - CAPD	0	0	0.00	0	0
6.00	Training - CCPD	0	0	0.00	0	0
7.00	Home Program - Hemodialysis	0	0	0.00	0	0
8.00	Home Program - Peritoneal Dialysis	0	0	0.00	0	0
		Patient Weeks			Patient Weeks	
		1.00	2.00	3.00	4.00	5.00
9.00	Home Program - CAPD	0	0	0.00	0	0
10.00	Home Program - CCPD	0	0	0.00	0	0
11.00	Totals (sum of lines 1 through 8, cols. 1 and 4) (sum of lines 1 through 10, cols. 2, 5, and 6) (see instruction)	1,063	921,383		316	273,902
12.00	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instruction)	1,063				
		Total Program Payment	Average Payment Rate (col. 6 ÷ col. 4)			
		6.00	7.00			
1.00	Maintenance - Hemodialysis	97,295	307.90			
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)	97,295				
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: 14-0300	Period: From 12/01/2020 To 11/30/2021	Worksheet I-5 Date/Time Prepared: 5/2/2022 11:40 am
		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)	273,902		1.00
2.00	Total payment due (from Wkst. I-4, col. 6, line 11) (see instructions)	97,295	97,295	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)	97,295	97,295	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	19,402	19,402	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)	19,402	19,402	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	19,402	8.00
9.00	Program payment (see instructions)	0	77,836	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)	921,383		12.00
13.00	Total composite costs (from Wkst. I-4, col. 2, line 11)	921,383		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: 14-0300

Period:
From 12/01/2020
To 11/30/2021Worksheet L
Parts I-III
Date/Time Prepared:
5/2/2022 11:40 am

		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		28,143	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		0	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		4.47	3.00
4.00	Number of interns & residents (see instructions)		5.53	4.00
5.00	Indirect medical education percentage (see instructions)		41.78	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)		11,758	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		39,901	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