

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: 14-0083	Period: From 07/01/2019 To 06/30/2020	Worksheet S Parts I-III Date/Time Prepared: 11/30/2020 9:31 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 11/30/2020	Time: 9:31 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by LORETTO HOSPITAL (14-0083) for the cost reporting period beginning 07/01/2019 and ending 06/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	118,623	-7,246	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	118,623	-7,246	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: 14-0083		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/30/2020 9:31 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 645 SOUTH CENTRAL AVENUE			PO Box:				1.00	
2.00	City: CHICAGO			State: IL		Zip Code: 60646		County: COOK	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			LORETTO HOSPITAL	140083	16974	1	07/01/1966	N
4.00	Subprovider - IPF							P	0
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
17.10	Hospital-Based (CORF) I								
17.20	Hospital-Based (OPT) I								
17.30	Hospital-Based (OOT) I								
17.40	Hospital-Based (OSP) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2019	06/30/2020	
21.00	Type of Control (see instructions)						2		
							1.00	2.00	
							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		
22.01	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		
22.02	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		
22.03	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	
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		

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Part I
Date/Time Prepared:
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0083		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/30/2020 9:31 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	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00		2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
						1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
		1.00	2.00	3.00			
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00		0.00	0.000000		64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
			1.00	2.00	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
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	76.00

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			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	N	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	N	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	N	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	N	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	N	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	N	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				
		1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N			110.00

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		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.	Y		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.	2		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	1,328,427	0	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:	Contractor's Name:		Contractor's Number:				141.00	
142.00	Street:	PO Box:						142.00	
143.00	City:	State:		Zip Code:				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.			Y		N		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.			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		155.00	
156.00	Subprovider - IPF	N		N		N		156.00	
157.00	Subprovider - IRF	N		N		N		157.00	
158.00	SUBPROVIDER							158.00	
159.00	SNF	N		N		N		159.00	
160.00	HOME HEALTH AGENCY	N		N		N		160.00	
161.00	CMHC			N		N		161.00	
161.10	CORF			N		N		161.10	
161.20	OUTPATIENT PHYSICAL THERAPY			N		N		161.20	
161.30	OUTPATIENT OCCUPATIONAL THERAPY			N		N		161.30	
161.40	OUTPATIENT SPEECH PATHOLOGY			N		N		161.40	
								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.							N	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)							0.00	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		171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0083	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 11/30/2020 9:31 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)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	11/03/2020	Y 11/03/2020
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part II
Date/Time Prepared:
11/30/2020 9:31 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.	JENNY	DABROWSKI		41.00
42.00	Enter the employer/company name of the cost report preparer.	STRATEGIC REIMBURSEMENT GROUP LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	331-225-0603	JENNY.DABROWSKI@SRGROUPLLC.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0083	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 11/30/2020 9:31 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.	MANAGER		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: 14-0083

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/30/2020 9:31 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	110	40,260	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)		110	40,260	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,392	0.00	0	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 DETOXIFICATION INTENSIVE CARE UNIT	35.00	0	0	0.00	0	12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		122	44,652	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
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	25.40
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		122				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: 14-0083

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/30/2020 9:31 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)	3,222	2,506	17,980			1.00
2.00	HMO and other (see instructions)	1,596	9,052				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)	3,222	2,506	17,980			7.00
8.00	INTENSIVE CARE UNIT	473	78	849			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	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0			12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	3,695	2,584	18,829	2.07	465.70	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
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0.00	0.00	25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0.00	0.00	25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0.00	0.00	25.40
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				2.07	465.70	27.00
28.00	Observation Bed Days		0	1,437			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: 14-0083

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/30/2020 9:31 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	615	571	4,022	1.00
2.00 HMO and other (see instructions)			311	2,187		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 DETOXIFICATION INTENSIVE CARE UNIT						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	615	571	4,022	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
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0.00					25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00					25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00					25.40
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part II
Date/Time Prepared:
11/30/2020 9:31 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	32,988,252	0	32,988,252	972,374.87	33.93
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	143,889	0	143,889	5,845.19	24.62
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)		1,748,346	0	1,748,346	74,064.45	23.61
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		0	0	0	0.00	0.00
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)		5,329,401	0	5,329,401		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		299,641	0	299,641		
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		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		24,660	0	24,660		
25.50	Home office wage-related (core)		0	0	0		
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: 14-0083

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part II
Date/Time Prepared:
11/30/2020 9:31 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	398,564	0	398,564	12,002.50	33.21	26.00
27.00	Administrative & General	5.00	7,579,534	0	7,579,534	174,840.25	43.35	27.00
28.00	Administrative & General under contract (see inst.)		118,282	0	118,282	571.30	207.04	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,219,685	0	1,219,685	34,884.09	34.96	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	858,516	0	858,516	50,576.08	16.97	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	694,695	-172,859	521,836	29,892.58	17.46	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	172,859	172,859	9,901.96	17.46	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,143,712	0	1,143,712	33,288.45	34.36	38.00
39.00	Central Services and Supply	14.00	168,940	0	168,940	9,385.59	18.00	39.00
40.00	Pharmacy	15.00	748,517	0	748,517	17,858.39	41.91	40.00
41.00	Medical Records & Medical Records Library	16.00	443,974	0	443,974	20,205.35	21.97	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: 14-0083

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part III
Date/Time Prepared:
11/30/2020 9:31 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)	32,962,645	0	32,962,645	967,100.98	34.08	1.00
2.00	Excluded area salaries (see instructions)	1,748,346	0	1,748,346	74,064.45	23.61	2.00
3.00	Subtotal salaries (line 1 minus line 2)	31,214,299	0	31,214,299	893,036.53	34.95	3.00
4.00	Subtotal other wages & related costs (see inst.)	0	0	0	0.00	0.00	4.00
5.00	Subtotal wage-related costs (see inst.)	5,329,401	0	5,329,401	0.00	17.07	5.00
6.00	Total (sum of lines 3 thru 5)	36,543,700	0	36,543,700	893,036.53	40.92	6.00
7.00	Total overhead cost (see instructions)	13,374,419	0	13,374,419	393,406.54	34.00	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part IV
Date/Time Prepared:
11/30/2020 9:31 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)	395,444	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	2,553,327	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	158,834	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	0	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	2,528,267	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	17,830	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)	5,653,702	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: 14-0083

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part V
Date/Time Prepared:
11/30/2020 9:31 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	5,653,702	1.00
2.00	Hospital	0	5,653,702	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
16.20	Hospital-Based-CMHC 20	0	0	16.20
16.30	Hospital-Based-CMHC 30	0	0	16.30
16.40	Hospital-Based-CMHC 40	0	0	16.40
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0083	Period: From 07/01/2019 To 06/30/2020	Worksheet S-10 Date/Time Prepared: 11/30/2020 9:31 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)		0.643884	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		8,989,683	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?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		3,764,568	5.00
6.00	Medicaid charges		23,912,012	6.00
7.00	Medicaid cost (line 1 times line 6)		15,396,562	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)		2,642,311	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)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	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)		2,642,311	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)	5,245,648	0	5,245,648
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,377,589	0	3,377,589
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	3,377,589	0	3,377,589
			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)		2,545,504	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		368,084	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		566,283	27.01
28.00	Non-Medicare bad debt expense (see instructions)		1,979,221	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,472,588	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		4,850,177	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		7,492,488	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020

Worksheet A

Date/Time Prepared:
11/30/2020 9:31 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati 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		2,701,498	2,701,498	-180,682	2,520,816	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	353,310	353,310	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	398,564	3,613,655	4,012,219	0	4,012,219	4.00
5.01	01160	COMMUNICATIONS	193,413	156,118	349,531	0	349,531	5.01
5.02	00591	COVID	380,013	2,398,350	2,778,363	0	2,778,363	5.02
5.04	00570	ADMITTING	189,961	33,008	222,969	0	222,969	5.04
5.05	00580	BUSINESS OFFICE	501,325	3,241,290	3,742,615	0	3,742,615	5.05
5.06	00590	OTHER ADMINISTRATIVE	6,314,822	14,015,196	20,330,018	-172,628	20,157,390	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,219,685	1,354,822	2,574,507	0	2,574,507	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	79,189	79,189	0	79,189	8.00
9.00	00900	HOUSEKEEPING	858,516	593,213	1,451,729	0	1,451,729	9.00
10.00	01000	DIETARY	694,695	1,574,611	2,269,306	-564,665	1,704,641	10.00
11.00	01100	CAFETERIA	0	0	0	564,665	564,665	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,143,712	241,551	1,385,263	0	1,385,263	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	168,940	-482,726	-313,786	-106,275	-420,061	14.00
15.00	01500	PHARMACY	748,517	1,224,486	1,973,003	-661,864	1,311,139	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	443,974	244,707	688,681	0	688,681	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	143,889	225,299	369,188	0	369,188	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,803,705	1,793,067	9,596,772	0	9,596,772	30.00
31.00	03100	INTENSIVE CARE UNIT	1,612,943	294,725	1,907,668	-35,716	1,871,952	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0	35.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	463,557	516,934	980,491	-207,568	772,923	50.00
53.00	05300	ANESTHESIOLOGY	0	160,000	160,000	0	160,000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,230,827	1,583,619	2,814,446	-73,015	2,741,431	54.00
57.00	05700	CT SCAN	109,382	30,226	139,608	0	139,608	57.00
60.00	06000	LABORATORY	814,482	2,281,876	3,096,358	0	3,096,358	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	660,061	144,773	804,834	-47,459	757,375	65.00
66.00	06600	PHYSICAL THERAPY	328,737	67,572	396,309	-1,748	394,561	66.00
69.00	06900	ELECTROCARDIOLOGY	80,787	32,316	113,103	0	113,103	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	12,583	1,227	13,810	0	13,810	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	587,269	587,269	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	657,520	657,520	73.00
74.00	07400	RENAL DIALYSIS	0	135,052	135,052	0	135,052	74.00
75.01	07501	HYPERBARIC CHAMBER	0	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	216,714	19,959	236,673	0	236,673	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	66,651	11,274	77,925	-3	77,922	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	0	90.01
90.02	09002	YMCA CLINIC	0	266	266	0	266	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	0	90.03
90.04	09004	CLINIC #4	0	0	0	0	0	90.04
90.05	09005	WOUND CARE	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	4,439,451	888,412	5,327,863	-111,141	5,216,722	91.00
91.01	09101	GOLDEN LIFE	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,239,906	39,175,565	70,415,471	0	70,415,471	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	PUBLIC RELATIONS	39,704	35,281	74,985	0	74,985	194.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020

Worksheet A

Date/Time Prepared:
11/30/2020 9:31 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	
194.01	07952	RESEARCH	123,227	-39,881	83,346	0	83,346	194.01
194.02	07953	OPMH	701,586	151,264	852,850	0	852,850	194.02
194.03	07954	CLINIC OTHER	883,829	1,240,745	2,124,574	0	2,124,574	194.03
194.10	07951	AUSTIN PRIDE	0	0	0	0	0	194.10
200.00		TOTAL (SUM OF LINES 118 through 199)	32,988,252	40,562,974	73,551,226	0	73,551,226	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020

Worksheet A

Date/Time Prepared:
11/30/2020 9:31 am

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-10,362	2,510,454	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	353,310	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,012,219	4.00
5.01	01160	COMMUNICATIONS	0	349,531	5.01
5.02	00591	COVID	0	2,778,363	5.02
5.04	00570	ADMITTING	0	222,969	5.04
5.05	00580	BUSINESS OFFICE	0	3,742,615	5.05
5.06	00590	OTHER ADMINISTRATIVE	-4,784,219	15,373,171	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	2,574,507	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	79,189	8.00
9.00	00900	HOUSEKEEPING	0	1,451,729	9.00
10.00	01000	DIETARY	0	1,704,641	10.00
11.00	01100	CAFETERIA	-101,774	462,891	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,385,263	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	-420,061	14.00
15.00	01500	PHARMACY	0	1,311,139	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	688,681	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	369,188	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-894,324	8,702,448	30.00
31.00	03100	INTENSIVE CARE UNIT	-98,000	1,773,952	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	35.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-325,105	447,818	50.00
53.00	05300	ANESTHESIOLOGY	-160,000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-219,399	2,522,032	54.00
57.00	05700	CT SCAN	0	139,608	57.00
60.00	06000	LABORATORY	0	3,096,358	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	757,375	65.00
66.00	06600	PHYSICAL THERAPY	0	394,561	66.00
69.00	06900	ELECTROCARDIOLOGY	0	113,103	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	13,810	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	587,269	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	657,520	73.00
74.00	07400	RENAL DIALYSIS	0	135,052	74.00
75.01	07501	HYPERBARIC CHAMBER	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	0	236,673	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	77,922	90.00
90.01	09001	CICERO CLINIC	0	0	90.01
90.02	09002	YMCA CLINIC	0	266	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	90.03
90.04	09004	CLINIC #4	0	0	90.04
90.05	09005	WOUND CARE	0	0	90.05
91.00	09100	EMERGENCY	-208,525	5,008,197	91.00
91.01	09101	GOLDEN LIFE	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-6,801,708	63,613,763	118.00
NONREIMBURSABLE COST CENTERS					
194.00	07950	PUBLIC RELATIONS	0	74,985	194.00
194.01	07952	RESEARCH	0	83,346	194.01
194.02	07953	OPMH	0	852,850	194.02

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020

Worksheet A

Date/Time Prepared:
11/30/2020 9:31 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
194.03	07954	CLINIC OTHER	0	2,124,574	194.03
194.10	07951	AUSTIN PRIDE	0	0	194.10
200.00		TOTAL (SUM OF LINES 118 through 199)	-6,801,708	66,749,518	200.00

RECLASSIFICATIONS

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020Worksheet A-6
Date/Time Prepared:
11/30/2020 9:31 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
1.00	A - DRUGS SOLD				1.00
	DRUGS CHARGED TO PATIENTS	73.00	0	657,520	
	TOTALS		0	657,520	
1.00	B - CAFETERIA RECLASS				1.00
	CAFETERIA	11.00	172,859	391,806	
	TOTALS		172,859	391,806	
1.00	D - DEPR EXP				1.00
	CAP REL COSTS-MVBLE EQUIP	2.00	0	283,660	
	TOTALS		0	283,660	
1.00	E - MEDICAL SUPPLIES CHARGED TO PATIENTS				1.00
	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	587,269	
		0.00	0	0	
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
	TOTALS		0	587,269	
	F - CAPITAL INSURANCE EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	102,978	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	69,650	2.00
	TOTALS		0	172,628	
500.00	Grand Total: Increases		172,859	2,092,883	500.00

RECLASSIFICATIONS

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-6

Date/Time Prepared:
11/30/2020 9:31 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1.00	A - DRUGS SOLD						1.00
	PHARMACY	15.00	0	657,520	0		
	TOTALS		0	657,520			
1.00	B - CAFETERIA RECLASS						1.00
	DIETARY	10.00	172,859	391,806	0		
	TOTALS		172,859	391,806			
1.00	D - DEPR EXP						1.00
	CAP REL COSTS-BLDG & FIXT	1.00	0	283,660	9		
	TOTALS		0	283,660			
1.00	E - MEDICAL SUPPLIES CHARGED TO PATIENTS						1.00
	OPERATING ROOM	50.00	0	207,568	0		
	RESPIRATORY THERAPY	65.00	0	47,459	0		
3.00	EMERGENCY	91.00	0	111,141	0		3.00
4.00	PHYSICAL THERAPY	66.00	0	1,748	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	106,275	0		5.00
6.00	PHARMACY	15.00	0	4,344	0		6.00
7.00	CLINIC	90.00	0	3	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	35,716	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	73,015	0		9.00
	TOTALS		0	587,269			
1.00	F - CAPITAL INSURANCE EXPENSE						1.00
	OTHER ADMINISTRATIVE	5.00	0	172,628	12		
	TOTALS	0.00	0	0	12		
500.00	Grand Total: Decreases		172,859	2,092,883			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part I
Date/Time Prepared:
11/30/2020 9:31 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	429,028	0	0	0	0	1.00
2.00	Land Improvements	52,143	0	0	0	0	2.00
3.00	Buildings and Fixtures	42,103,904	0	0	0	279,690	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	11,607,331	0	0	0	59,537	5.00
6.00	Movable Equipment	0	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)	54,192,406	0	0	0	339,227	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	54,192,406	0	0	0	339,227	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	429,028	0	1.00			
2.00	Land Improvements	52,143	0	2.00			
3.00	Buildings and Fixtures	41,824,214	0	3.00			
4.00	Building Improvements	0	0	4.00			
5.00	Fixed Equipment	11,547,794	0	5.00			
6.00	Movable Equipment	0	0	6.00			
7.00	HIT designated Assets	0	0	7.00			
8.00	Subtotal (sum of lines 1-7)	53,853,179	0	8.00			
9.00	Reconciling Items	0	0	9.00			
10.00	Total (line 8 minus line 9)	53,853,179	0	10.00			

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part II
Date/Time Prepared:
11/30/2020 9:31 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	2,418,300	0	283,198	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,418,300	0	283,198	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	2,701,498				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	2,701,498				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part III
Date/Time Prepared:
11/30/2020 9:31 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	42,305,384	0	42,305,384	0.785569	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	11,547,794	0	11,547,794	0.214431	0	2.00
3.00	Total (sum of lines 1-2)	53,853,178	0	53,853,178	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	2,124,278	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	283,660	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,407,938	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	283,198	102,978	0	0	2,510,454	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	69,650	0	0	353,310	2.00
3.00	Total (sum of lines 1-2)	283,198	172,628	0	0	2,863,764	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8

Date/Time Prepared:
11/30/2020 9:31 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	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,859,260			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-101,774	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME	B	-54,861	OTHER ADMINISTRATIVE	5.06	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8

Date/Time Prepared:
11/30/2020 9:31 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	
33.02	TELEPHONE CAPITAL	A	-2,282	CAP REL COSTS-BLDG & FIXT	1.00	9	33.02
35.00	MED REC COPIES	B	-3,152	OPERATING ROOM	50.00	0	35.00
37.00	LOBBYING EXPENSES	A	-7,731	OTHER ADMINISTRATIVE	5.06	0	37.00
38.00	RENTAL INCOME	B	-8,080	CAP REL COSTS-BLDG & FIXT	1.00	9	38.00
39.00	MEDICAID TAX ASSESSMENT	A	-3,764,568	OTHER ADMINISTRATIVE	5.06	0	39.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,801,708				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8-2

Date/Time Prepared:
11/30/2020 9:31 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	5.00	AGGREGATE-OTHER ADMINISTRATIVE	957,059	957,059	0	0	0	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	894,324	894,324	0	0	0	2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	98,000	98,000	0	0	0	3.00
4.00	50.00	AGGREGATE-OPERATING ROOM	321,953	321,953	0	0	0	4.00
5.00	53.00	AGGREGATE-ANESTHESIOLOGY	160,000	160,000	0	0	0	5.00
6.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	219,399	219,399	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	91.00	AGGREGATE-EMERGENCY	208,525	208,525	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,859,260	2,859,260	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	AGGREGATE-OTHER ADMINISTRATIVE	0	0	0	0	0	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	AGGREGATE-OTHER ADMINISTRATIVE	0	0	0	957,059		1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	894,324		2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	98,000		3.00
4.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	321,953		4.00
5.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	160,000		5.00
6.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	219,399		6.00
7.00	0.00		0	0	0	0		7.00
8.00	91.00	AGGREGATE-EMERGENCY	0	0	0	208,525		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,859,260		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/30/2020 9:31 am

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,510,454	2,510,454			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	353,310	353,310			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,012,219	15,646	2,202	4,030,067	4.00
5.01	01160	COMMUNICATIONS	349,531	15,177	2,136	23,918	5.01
5.02	00591	COVID	2,778,363	0	0	46,993	5.02
5.04	00570	ADMITTING	222,969	1,961	276	23,491	5.04
5.05	00580	BUSINESS OFFICE	3,742,615	41,878	5,894	61,994	5.05
5.06	00590	OTHER ADMINISTRATIVE	15,373,171	549,274	77,302	780,897	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	2,574,507	263,063	37,022	150,827	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	79,189	32,300	4,546	0	8.00
9.00	00900	HOUSEKEEPING	1,451,729	31,306	4,406	106,165	9.00
10.00	01000	DIETARY	1,704,641	83,060	11,689	64,531	10.00
11.00	01100	CAFETERIA	462,891	35,853	5,046	21,376	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,385,263	9,450	1,330	141,433	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-420,061	151,796	21,363	20,891	14.00
15.00	01500	PHARMACY	1,311,139	17,223	2,424	92,562	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	688,681	22,310	3,140	54,902	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	369,188	5,457	768	17,793	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,702,448	389,124	54,764	965,009	30.00
31.00	03100	INTENSIVE CARE UNIT	1,773,952	90,577	12,747	199,458	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	35.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	447,818	128,007	18,015	57,324	50.00
53.00	05300	ANESTHESIOLOGY	0	5,173	728	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,522,032	116,596	16,409	152,205	54.00
57.00	05700	CT SCAN	139,608	7,958	1,120	13,526	57.00
60.00	06000	LABORATORY	3,096,358	94,130	13,247	100,720	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	757,375	29,302	4,124	81,624	65.00
66.00	06600	PHYSICAL THERAPY	394,561	44,976	6,330	40,652	66.00
69.00	06900	ELECTROCARDIOLOGY	113,103	8,185	1,152	9,990	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	13,810	5,556	782	1,556	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	587,269	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	657,520	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	135,052	0	0	0	74.00
75.01	07501	HYPERBARIC CHAMBER	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	236,673	97,668	13,745	26,799	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	77,922	2,515	354	8,242	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	90.01
90.02	09002	YMCA CLINIC	266	0	0	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	90.03
90.04	09004	CLINIC #4	0	0	0	0	90.04
90.05	09005	WOUND CARE	0	0	0	0	90.05
91.00	09100	EMERGENCY	5,008,197	126,615	17,819	548,987	91.00
91.01	09101	GOLDEN LIFE	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	63,613,763	2,422,136	340,880	3,813,865	370,825

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Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
NONREIMBURSABLE COST CENTERS								
194.00	07950	PUBLIC RELATIONS	74,985	0	0	4,910	1,994	194.00
194.01	07952	RESEARCH	83,346	3,979	560	15,238	0	194.01
194.02	07953	OPMH	852,850	50,959	7,172	86,759	13,956	194.02
194.03	07954	CLINIC OTHER	2,124,574	33,380	4,698	109,295	0	194.03
194.10	07951	AUSTIN PRIDE	0	0	0	0	3,987	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	66,749,518	2,510,454	353,310	4,030,067	390,762	202.00

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Cost Center Description			Subtotal	COVID	ADMITTING	BUSINESS OFFICE	Subtotal	
			5A.01	5.02	5.04	5.05	5A.05	
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
5.01	01160	COMMUNICATIONS						5.01
5.02	00591	COVID	2,825,356	2,825,356				5.02
5.04	00570	ADMITTING	252,684	11,130	263,814			5.04
5.05	00580	BUSINESS OFFICE	3,858,362	169,949	0	4,028,311		5.05
5.06	00590	OTHER ADMINISTRATIVE	16,898,272	744,317	0	0	17,642,589	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	3,031,400	133,524	0	0	3,164,924	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	118,029	5,199	0	0	123,228	8.00
9.00	00900	HOUSEKEEPING	1,595,600	70,281	0	0	1,665,881	9.00
10.00	01000	DIETARY	1,873,889	82,539	0	0	1,956,428	10.00
11.00	01100	CAFETERIA	531,147	23,395	0	0	554,542	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,557,413	68,599	0	0	1,626,012	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-220,030	0	0	0	-220,030	14.00
15.00	01500	PHARMACY	1,427,335	62,870	0	0	1,490,205	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	782,989	34,488	0	0	817,477	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	393,206	17,320	0	0	410,526	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,141,250	446,692	119,524	1,582,726	12,290,192	30.00
31.00	03100	INTENSIVE CARE UNIT	2,086,702	91,913	21,455	184,995	2,385,065	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0	35.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	689,044	30,350	5,482	98,695	823,571	50.00
53.00	05300	ANESTHESIOLOGY	7,895	348	480	9,568	18,291	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,823,191	124,353	4,921	126,402	3,078,867	54.00
57.00	05700	CT SCAN	162,212	7,145	3,718	111,221	284,296	57.00
60.00	06000	LABORATORY	3,316,417	146,078	26,006	448,563	3,937,064	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	876,412	38,603	13,871	164,882	1,093,768	65.00
66.00	06600	PHYSICAL THERAPY	500,475	22,044	1,938	35,970	560,427	66.00
69.00	06900	ELECTROCARDIOLOGY	138,411	6,097	4,801	60,663	209,972	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	23,698	1,044	62	555	25,359	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	587,269	25,867	4,050	99,074	716,260	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	657,520	28,962	33,341	373,213	1,093,036	73.00
74.00	07400	RENAL DIALYSIS	135,052	5,949	389	3,351	144,741	74.00
75.01	07501	HYPERBARIC CHAMBER	0	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	378,872	16,688	4	65,423	460,987	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	91,027	4,009	163	4,991	100,190	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	0	90.01
90.02	09002	YMCA CLINIC	266	12	0	0	278	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	0	90.03
90.04	09004	CLINIC #4	0	0	0	0	0	90.04
90.05	09005	WOUND CARE	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	5,735,511	252,632	23,609	658,019	6,669,771	91.00
91.01	09101	GOLDEN LIFE	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	63,276,876	2,672,397	263,814	4,028,311	63,123,917	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	PUBLIC RELATIONS	81,889	3,607	0	0	85,496	194.00
194.01	07952	RESEARCH	103,123	4,542	0	0	107,665	194.01
194.02	07953	OPMH	1,011,696	44,562	0	0	1,056,258	194.02
194.03	07954	CLINIC OTHER	2,271,947	100,072	0	0	2,372,019	194.03

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Cost Center Description			Subtotal	COVID	ADMITTING	BUSINESS OFFICE	Subtotal	
			5A.01	5.02	5.04	5.05	5A.05	
194.10	07951	AUSTIN PRIDE	3,987	176	0	0	4,163	194.10
200.00		Cross Foot Adjustments	0				0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	66,749,518	2,825,356	263,814	4,028,311	66,749,518	202.00

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Cost Center Description			OTHER ADMINISTRATIVE	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.06	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
5.01	01160	COMMUNICATIONS						5.01
5.02	00591	COVID						5.02
5.04	00570	ADMITTING						5.04
5.05	00580	BUSINESS OFFICE						5.05
5.06	00590	OTHER ADMINISTRATIVE	17,642,589					5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	1,131,986	0	4,296,910			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	44,074	0	85,491	252,793		8.00
9.00	00900	HOUSEKEEPING	595,829	0	82,859	0	2,344,569	9.00
10.00	01000	DIETARY	699,748	0	219,840	0	100,284	10.00
11.00	01100	CAFETERIA	198,341	0	94,894	0	33,195	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	581,569	0	25,012	0	111,629	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	401,768	0	31,514	14.00
15.00	01500	PHARMACY	532,996	0	45,585	0	59,877	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	292,384	0	59,050	0	67,790	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	146,831	0	14,443	0	19,609	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,395,795	0	1,029,922	165,017	816,773	30.00
31.00	03100	INTENSIVE CARE UNIT	853,057	0	239,737	12,027	107,568	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0	35.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	294,563	0	338,806	75,749	35,086	50.00
53.00	05300	ANESTHESIOLOGY	6,542	0	13,691	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,101,206	0	308,604	0	119,683	54.00
57.00	05700	CT SCAN	101,683	0	21,063	0	7,773	57.00
60.00	06000	LABORATORY	1,408,154	0	249,140	0	102,525	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	391,204	0	77,555	0	62,188	65.00
66.00	06600	PHYSICAL THERAPY	200,446	0	119,041	0	36,206	66.00
69.00	06900	ELECTROCARDIOLOGY	75,100	0	21,664	0	12,115	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	9,070	0	14,706	0	1,821	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	256,182	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	390,942	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	51,769	0	0	0	0	74.00
75.01	07501	HYPERBARIC CHAMBER	0	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	164,879	0	258,505	0	65,479	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	35,835	0	6,657	0	7,423	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	0	90.01
90.02	09002	YMCA CLINIC	99	0	0	0	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	0	90.03
90.04	09004	CLINIC #4	0	0	0	0	0	90.04
90.05	09005	WOUND CARE	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	2,385,550	0	335,120	0	297,562	91.00
91.01	09101	GOLDEN LIFE	0	0	0	0	0	91.01
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
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,345,834	0	4,063,153	252,793	2,096,100	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	PUBLIC RELATIONS	30,579	0	0	0	4,902	194.00
194.01	07952	RESEARCH	38,508	0	10,531	0	13,936	194.01
194.02	07953	OPMH	377,788	0	134,876	0	106,797	194.02
194.03	07954	CLINIC OTHER	848,391	0	88,350	0	122,834	194.03

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Cost Center Description			OTHER ADMINISTRATIVE 5.06	MAINTENANCE & REPAIRS 6.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	
194.10	07951	AUSTIN PRIDE	1,489	0	0	0	0	194.10
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)	17,642,589	0	4,296,910	252,793	2,344,569	202.00

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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
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
5.01	01160	COMMUNICATIONS						5.01
5.02	00591	COVID						5.02
5.04	00570	ADMITTING						5.04
5.05	00580	BUSINESS OFFICE						5.05
5.06	00590	OTHER ADMINISTRATIVE						5.06
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	2,976,300					10.00
11.00	01100	CAFETERIA		880,972				11.00
12.00	01200	MAINTENANCE OF PERSONNEL			0			12.00
13.00	01300	NURSING ADMINISTRATION		44,477	0	2,388,699		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		12,556	0		225,808	14.00
15.00	01500	PHARMACY		23,857	0	0	277	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		27,010	0	0	0	16.00
17.00	01700	SOCIAL SERVICE		0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		0	0	0	0	19.00
20.00	02000	NURSING SCHOOL		0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV		7,813	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)		0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,869,078	325,427	0	1,552,158	32,010	30.00
31.00	03100	INTENSIVE CARE UNIT	107,222	42,859	0	204,398	1,568	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0	35.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	13,979	0	66,718	4,512	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	47,686	0	0	2,458	54.00
57.00	05700	CT SCAN	0	3,097	0	0	0	57.00
60.00	06000	LABORATORY	0	40,850	0	0	68,237	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	24,778	0	0	970	65.00
66.00	06600	PHYSICAL THERAPY	0	14,426	0	0	38	66.00
69.00	06900	ELECTROCARDIOLOGY	0	4,827	0	0	45	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	725	0	0	11	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	91,479	71.00
72.00	07200	IMPLANTABLE DEVICES 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
75.01	07501	HYPERBARIC CHAMBER	0	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	0	26,089	0	0	116	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	2,958	0	0	1,108	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	0	90.01
90.02	09002	YMCA CLINIC	0	0	0	0	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	0	90.03
90.04	09004	CLINIC #4	0	0	0	0	0	90.04
90.05	09005	WOUND CARE	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	118,559	0	565,425	12,598	91.00
91.01	09101	GOLDEN LIFE	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,976,300	781,973	0	2,388,699	215,427	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	PUBLIC RELATIONS	0	1,953	0	0	0	194.00
194.01	07952	RESEARCH	0	5,553	0	0	0	194.01
194.02	07953	OPMH	0	42,552	0	0	28	194.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0083

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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
194.03	07954	CLINIC OTHER	0	48,941	0	0	10,353	194.03
194.10	07951	AUSTIN PRIDE	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,976,300	880,972	0	2,388,699	225,808	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
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
5.01	01160	COMMUNICATIONS						5.01
5.02	00591	COVID						5.02
5.04	00570	ADMITTING						5.04
5.05	00580	BUSINESS OFFICE						5.05
5.06	00590	OTHER ADMINISTRATIVE						5.06
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	2,152,797					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,263,711				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
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	0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,079	496,537	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	236	58,032	0	0	0	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0	35.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,995	30,960	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	3,002	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	207	39,652	0	0	0	54.00
57.00	05700	CT SCAN	0	34,890	0	0	0	57.00
60.00	06000	LABORATORY	0	140,713	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	51,723	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	11,284	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	16	19,030	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	174	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	31,079	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,742,685	117,076	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	1,051	0	0	0	74.00
75.01	07501	HYPERBARIC CHAMBER	0	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	0	20,523	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1,566	0	0	0	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	0	90.01
90.02	09002	YMCA CLINIC	0	0	0	0	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	0	90.03
90.04	09004	CLINIC #4	0	0	0	0	0	90.04
90.05	09005	WOUND CARE	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	76,106	206,419	0	0	0	91.00
91.01	09101	GOLDEN LIFE	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,836,324	1,263,711	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	PUBLIC RELATIONS	0	0	0	0	0	194.00
194.01	07952	RESEARCH	0	0	0	0	0	194.01
194.02	07953	OPMH	8,831	0	0	0	0	194.02

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
194.03	07954	CLINIC OTHER	307,642	0	0	0	0	194.03
194.10	07951	AUSTIN PRIDE	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	2,152,797	1,263,711	0	0		202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00				
			23.00	24.00	25.00			
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00591	COVID						5.02
5.04	00570	ADMITTING						5.04
5.05	00580	BUSINESS OFFICE						5.05
5.06	00590	OTHER ADMINISTRATIVE						5.06
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	599,222					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	599,222	0	0	24,579,210	-599,222	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	4,011,769	0	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0	35.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	1,693,939	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	41,526	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	4,698,363	0	54.00
57.00	05700	CT SCAN	0	0	0	452,802	0	57.00
60.00	06000	LABORATORY	0	0	0	5,946,683	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,702,186	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	941,868	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	342,769	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	51,866	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,095,000	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,343,739	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	197,561	0	74.00
75.01	07501	HYBERBARIC CHAMBER	0	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	0	0	0	996,578	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	155,737	0	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	0	90.01
90.02	09002	YMCA CLINIC	0	0	0	377	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	0	90.03
90.04	09004	CLINIC #4	0	0	0	0	0	90.04
90.05	09005	WOUND CARE	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	10,667,110	0	91.00
91.01	09101	GOLDEN LIFE	0	0	0	0	0	91.01
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
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	599,222	0	0	60,919,083	-599,222	118.00

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00				
NONREIMBURSABLE COST CENTERS								
194.00	07950	PUBLIC RELATIONS	0	0	0	122,930	0	194.00
194.01	07952	RESEARCH	0	0	0	176,193	0	194.01
194.02	07953	OPMH	0	0	0	1,727,130	0	194.02
194.03	07954	CLINIC OTHER	0	0	0	3,798,530	0	194.03
194.10	07951	AUSTIN PRIDE	0	0	0	5,652	0	194.10
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	599,222	0	0	66,749,518	-599,222	202.00

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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	01160	COMMUNICATIONS	5.01
5.02	00591	COVID	5.02
5.04	00570	ADMITTING	5.04
5.05	00580	BUSINESS OFFICE	5.05
5.06	00590	OTHER ADMINISTRATIVE	5.06
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
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
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
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	35.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
57.00	05700	CT SCAN	57.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
75.01	07501	HYPERBARIC CHAMBER	75.01
76.00	03550	O/P MENTAL HEALTH	76.00
76.10	03950	PARTIAL HOSPITALIZATION	76.10
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
90.01	09001	CICERO CLINIC	90.01
90.02	09002	YMCA CLINIC	90.02
90.03	09003	NORTH AVENUE CLINIC	90.03
90.04	09004	CLINIC #4	90.04
90.05	09005	WOUND CARE	90.05
91.00	09100	EMERGENCY	91.00
91.01	09101	GOLDEN LIFE	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	99.40
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
194.00	07950	PUBLIC RELATIONS	194.00
194.01	07952	RESEARCH	194.01
194.02	07953	OPMH	194.02
194.03	07954	CLINIC OTHER	194.03
194.10	07951	AUSTIN PRIDE	194.10

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Cost Center Description		Total	
		26.00	
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118 through 201)	66,150,296	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	15,646	2,202	17,848	4.00
5.01	01160	COMMUNICATIONS	0	15,177	2,136	17,313	5.01
5.02	00591	COVID	0	0	0	208	5.02
5.04	00570	ADMITTING	0	1,961	276	2,237	5.04
5.05	00580	BUSINESS OFFICE	0	41,878	5,894	47,772	5.05
5.06	00590	OTHER ADMINISTRATIVE	54,740	549,274	77,302	681,316	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	263,063	37,022	300,085	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	32,300	4,546	36,846	8.00
9.00	00900	HOUSEKEEPING	0	31,306	4,406	35,712	9.00
10.00	01000	DIETARY	0	83,060	11,689	94,749	10.00
11.00	01100	CAFETERIA	0	35,853	5,046	40,899	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	9,450	1,330	10,780	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	151,796	21,363	173,159	14.00
15.00	01500	PHARMACY	57,007	17,223	2,424	76,654	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	22,310	3,140	25,450	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	5,457	768	6,225	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	908	389,124	54,764	444,796	30.00
31.00	03100	INTENSIVE CARE UNIT	0	90,577	12,747	103,324	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	35.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	128,007	18,015	146,022	50.00
53.00	05300	ANESTHESIOLOGY	0	5,173	728	5,901	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	620	116,596	16,409	133,625	54.00
57.00	05700	CT SCAN	0	7,958	1,120	9,078	57.00
60.00	06000	LABORATORY	0	94,130	13,247	107,377	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	10,192	29,302	4,124	43,618	65.00
66.00	06600	PHYSICAL THERAPY	0	44,976	6,330	51,306	66.00
69.00	06900	ELECTROCARDIOLOGY	0	8,185	1,152	9,337	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,556	782	6,338	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES 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
75.01	07501	HYPERBARIC CHAMBER	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	0	97,668	13,745	111,413	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	15,289	2,515	354	18,158	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	90.01
90.02	09002	YMCA CLINIC	0	0	0	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	90.03
90.04	09004	CLINIC #4	0	0	0	0	90.04
90.05	09005	WOUND CARE	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	126,615	17,819	144,434	91.00
91.01	09101	GOLDEN LIFE	0	0	0	0	91.01
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
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	138,756	2,422,136	340,880	2,901,772	118.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	PUBLIC RELATIONS	0	0	0	22	194.00
194.01	07952	RESEARCH	0	3,979	560	68	194.01
194.02	07953	OPMH	42,000	50,959	7,172	384	194.02
194.03	07954	CLINIC OTHER	114,750	33,380	4,698	484	194.03
194.10	07951	AUSTIN PRIDE	0	0	0	0	194.10
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)	295,506	2,510,454	353,310	17,848	202.00

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Cost Center Description			COMMUNICATIONS	COVID	ADMITTING	BUSINESS OFFICE	OTHER ADMINISTRATIVE	
			5.01	5.02	5.04	5.05	5.06	
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
5.01	01160	COMMUNICATIONS	17,419					5.01
5.02	00591	COVID	0	208				5.02
5.04	00570	ADMITTING	178	1	2,520			5.04
5.05	00580	BUSINESS OFFICE	267	12	0	48,326		5.05
5.06	00590	OTHER ADMINISTRATIVE	5,240	68	0	0	690,085	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	267	9	0		44,277	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	89	0	0	0	1,724	8.00
9.00	00900	HOUSEKEEPING	89	5	0	0	23,306	9.00
10.00	01000	DIETARY	444	6	0	0	27,370	10.00
11.00	01100	CAFETERIA	267	2	0	0	7,758	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	889	5	0	0	22,748	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	267	0	0	0	0	14.00
15.00	01500	PHARMACY	178	4	0	0	20,848	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	622	2	0	0	11,437	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	1	0	0	5,743	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,333	30	1,129	18,977	171,940	30.00
31.00	03100	INTENSIVE CARE UNIT	444	6	207	2,220	33,367	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0	35.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,689	2	53	1,184	11,522	50.00
53.00	05300	ANESTHESIOLOGY	89	0	5	115	256	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	711	8	47	1,517	43,073	54.00
57.00	05700	CT SCAN	0	0	36	1,335	3,977	57.00
60.00	06000	LABORATORY	533	10	250	5,383	55,080	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	178	3	134	1,979	15,302	65.00
66.00	06600	PHYSICAL THERAPY	622	2	19	432	7,840	66.00
69.00	06900	ELECTROCARDIOLOGY	267	0	46	728	2,938	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	89	0	1	7	355	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2	39	1,189	10,020	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2	321	4,479	15,292	73.00
74.00	07400	RENAL DIALYSIS	0	0	4	40	2,025	74.00
75.01	07501	HYPERBARIC CHAMBER	0	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	178	1	0	785	6,449	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	89	0	2	60	1,402	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	0	90.01
90.02	09002	YMCA CLINIC	0	0	0	0	4	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	0	90.03
90.04	09004	CLINIC #4	0	0	0	0	0	90.04
90.05	09005	WOUND CARE	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	1,511	17	227	7,896	93,310	91.00
91.01	09101	GOLDEN LIFE	0	0	0	0	0	91.01
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
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,530	198	2,520	48,326	639,363	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	PUBLIC RELATIONS	89	0	0	0	1,196	194.00
194.01	07952	RESEARCH	0	0	0	0	1,506	194.01
194.02	07953	OPMH	622	3	0	0	14,777	194.02
194.03	07954	CLINIC OTHER	0	7	0	0	33,185	194.03

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Cost Center Description			COMMUNICATIONS	COVID	ADMITTING	BUSINESS OFFICE	OTHER ADMINISTRATIVE	
			5.01	5.02	5.04	5.05	5.06	
194.10	07951	AUSTIN PRIDE	178	0	0	0	58	194.10
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)	17,419	208	2,520	48,326	690,085	202.00

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Cost Center Description			MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			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
5.01	01160	COMMUNICATIONS						5.01
5.02	00591	COVID						5.02
5.04	00570	ADMITTING						5.04
5.05	00580	BUSINESS OFFICE						5.05
5.06	00590	OTHER ADMINISTRATIVE						5.06
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	345,306				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,870	45,529			8.00
9.00	00900	HOUSEKEEPING	0	6,659	0	66,241		9.00
10.00	01000	DIETARY	0	17,667	0	2,833	143,355	10.00
11.00	01100	CAFETERIA	0	7,626	0	938	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	2,010	0	3,154	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	32,287	0	890	0	14.00
15.00	01500	PHARMACY	0	3,663	0	1,692	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,745	0	1,915	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	1,161	0	554	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	82,765	29,720	23,077	138,191	30.00
31.00	03100	INTENSIVE CARE UNIT	0	19,266	2,166	3,039	5,164	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0	35.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	27,227	13,643	991	0	50.00
53.00	05300	ANESTHESIOLOGY	0	1,100	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	24,800	0	3,381	0	54.00
57.00	05700	CT SCAN	0	1,693	0	220	0	57.00
60.00	06000	LABORATORY	0	20,021	0	2,897	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	6,232	0	1,757	0	65.00
66.00	06600	PHYSICAL THERAPY	0	9,566	0	1,023	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,741	0	342	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,182	0	51	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES 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
75.01	07501	HYPERBARIC CHAMBER	0	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	0	20,774	0	1,850	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	535	0	210	0	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	0	90.01
90.02	09002	YMCA CLINIC	0	0	0	0	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	0	90.03
90.04	09004	CLINIC #4	0	0	0	0	0	90.04
90.05	09005	WOUND CARE	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	26,931	0	8,407	0	91.00
91.01	09101	GOLDEN LIFE	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	326,521	45,529	59,221	143,355	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	PUBLIC RELATIONS	0	0	0	139	0	194.00
194.01	07952	RESEARCH	0	846	0	394	0	194.01
194.02	07953	OPMH	0	10,839	0	3,017	0	194.02
194.03	07954	CLINIC OTHER	0	7,100	0	3,470	0	194.03

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Cost Center Description			MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			6.00	7.00	8.00	9.00	10.00	
194.10	07951	AUSTIN PRIDE	0	0	0	0	0	194.10
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)	0	345,306	45,529	66,241	143,355	202.00

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Cost Center Description			CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	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
5.01	01160	COMMUNICATIONS						5.01
5.02	00591	COVID						5.02
5.04	00570	ADMITTING						5.04
5.05	00580	BUSINESS OFFICE						5.05
5.06	00590	OTHER ADMINISTRATIVE						5.06
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	57,585					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	2,907	0	43,120			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	821	0	0	72,552		14.00
15.00	01500	PHARMACY	1,559	0	0	89	105,097	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,766	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	511	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	21,272	0	28,019	10,285	346	30.00
31.00	03100	INTENSIVE CARE UNIT	2,801	0	3,690	504	12	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0	35.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	914	0	1,204	1,450	488	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,117	0	0	790	10	54.00
57.00	05700	CT SCAN	202	0	0	202	0	57.00
60.00	06000	LABORATORY	2,670	0	0	21,924	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,620	0	0	312	0	65.00
66.00	06600	PHYSICAL THERAPY	943	0	0	12	0	66.00
69.00	06900	ELECTROCARDIOLOGY	316	0	0	14	1	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	47	0	0	4	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	29,392	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	85,075	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.01	07501	HYPERBARIC CHAMBER	0	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	1,705	0	0	37	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	193	0	0	356	0	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	0	90.01
90.02	09002	YMCA CLINIC	0	0	0	0	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	0	90.03
90.04	09004	CLINIC #4	0	0	0	0	0	90.04
90.05	09005	WOUND CARE	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	7,750	0	10,207	4,048	3,715	91.00
91.01	09101	GOLDEN LIFE	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	51,114	0	43,120	69,217	89,647	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	PUBLIC RELATIONS	128	0	0	0	0	194.00
194.01	07952	RESEARCH	363	0	0	0	0	194.01
194.02	07953	OPMH	2,781	0	0	9	431	194.02

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
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Cost Center Description			CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
194.03	07954	CLINIC OTHER	3,199	0	0	3,326	15,019	194.03
194.10	07951	AUSTIN PRIDE	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	134,965	0	201.00
202.00		TOTAL (sum lines 118 through 201)	57,585	0	43,120	207,517	105,097	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0083

Period:
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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV	
			16.00	17.00	19.00	20.00	21.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00591	COVID						5.02
5.04	00570	ADMITTING						5.04
5.05	00580	BUSINESS OFFICE						5.05
5.06	00590	OTHER ADMINISTRATIVE						5.06
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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	46,180					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			14,274	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,142	0				30.00
31.00	03100	INTENSIVE CARE UNIT	2,121	0				31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0				35.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,132	0				50.00
53.00	05300	ANESTHESIOLOGY	110	0				53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,449	0				54.00
57.00	05700	CT SCAN	1,275	0				57.00
60.00	06000	LABORATORY	5,143	0				60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62.30
65.00	06500	RESPIRATORY THERAPY	1,890	0				65.00
66.00	06600	PHYSICAL THERAPY	412	0				66.00
69.00	06900	ELECTROCARDIOLOGY	696	0				69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	6	0				70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,136	0				71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0				72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,279	0				73.00
74.00	07400	RENAL DIALYSIS	38	0				74.00
75.01	07501	HYPERBARIC CHAMBER	0	0				75.01
76.00	03550	O/P MENTAL HEALTH	0	0				76.00
76.10	03950	PARTIAL HOSPITALIZATION	750	0				76.10
76.97	07697	CARDIAC REHABILITATION	0	0				76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0				76.98
76.99	07699	LITHOTRIPSY	0	0				76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	57	0				90.00
90.01	09001	CICERO CLINIC	0	0				90.01
90.02	09002	YMCA CLINIC	0	0				90.02
90.03	09003	NORTH AVENUE CLINIC	0	0				90.03
90.04	09004	CLINIC #4	0	0				90.04
90.05	09005	WOUND CARE	0	0				90.05
91.00	09100	EMERGENCY	7,544	0				91.00
91.01	09101	GOLDEN LIFE	0	0				91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0				99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	46,180	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	PUBLIC RELATIONS	0	0				194.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0083

Period:
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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV	
			16.00	17.00	19.00	20.00	21.00	
194.01	07952	RESEARCH	0	0				194.01
194.02	07953	OPMH	0	0				194.02
194.03	07954	CLINIC OTHER	0	0				194.03
194.10	07951	AUSTIN PRIDE	0	0				194.10
200.00		Cross Foot Adjustments			0	0	14,274	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	46,180	0	0	0	14,274	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
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Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			SERVICES-OTHER PRGM COSTS APPRV					
			22.00	23.00	24.00	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
5.01	01160	COMMUNICATIONS						5.01
5.02	00591	COVID						5.02
5.04	00570	ADMITTING						5.04
5.05	00580	BUSINESS OFFICE						5.05
5.06	00590	OTHER ADMINISTRATIVE						5.06
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0					22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS			994,287	0	994,287	30.00
31.00	03100	INTENSIVE CARE UNIT			179,215	0	179,215	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT			0	0	0	35.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM			207,775	0	207,775	50.00
53.00	05300	ANESTHESIOLOGY			7,576	0	7,576	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC			213,202	0	213,202	54.00
57.00	05700	CT SCAN			17,876	0	17,876	57.00
60.00	06000	LABORATORY			221,734	0	221,734	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS			0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY			73,387	0	73,387	65.00
66.00	06600	PHYSICAL THERAPY			72,357	0	72,357	66.00
69.00	06900	ELECTROCARDIOLOGY			16,470	0	16,470	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY			8,087	0	8,087	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT			41,778	0	41,778	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS			0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS			109,448	0	109,448	73.00
74.00	07400	RENAL DIALYSIS			2,107	0	2,107	74.00
75.01	07501	HYPERBARIC CHAMBER			0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH			0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION			144,061	0	144,061	76.10
76.97	07697	CARDIAC REHABILITATION			0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY			0	0	0	76.98
76.99	07699	LITHOTRIPSY			0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC			21,099	0	21,099	90.00
90.01	09001	CICERO CLINIC			0	0	0	90.01
90.02	09002	YMCA CLINIC			4	0	4	90.02
90.03	09003	NORTH AVENUE CLINIC			0	0	0	90.03
90.04	09004	CLINIC #4			0	0	0	90.04
90.05	09005	WOUND CARE			0	0	0	90.05
91.00	09100	EMERGENCY			318,430	0	318,430	91.00
91.01	09101	GOLDEN LIFE			0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF			0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY			0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY			0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY			0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	2,648,893	0	2,648,893	118.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0083

Period:
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To 06/30/2020Worksheet B
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Cost Center Description		INTERNS & RESIDENTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		SERVICES-OTHER					
		PRGM COSTS APPRV					
		22.00	23.00	24.00	25.00	26.00	
NONREIMBURSABLE COST CENTERS							
194.00	07950	PUBLIC RELATIONS		1,574	0	1,574	194.00
194.01	07952	RESEARCH		7,716	0	7,716	194.01
194.02	07953	OPMH		132,994	0	132,994	194.02
194.03	07954	CLINIC OTHER		218,618	0	218,618	194.03
194.10	07951	AUSTIN PRIDE		236	0	236	194.10
200.00		Cross Foot Adjustments	0	14,274	0	14,274	200.00
201.00		Negative Cost Centers	0	134,965	0	134,965	201.00
202.00		TOTAL (sum lines 118 through 201)	0	3,159,270	0	3,159,270	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/30/2020 9:31 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (PHONES)	Reconciliation	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00				
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	176,663					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		176,663				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,101	1,101	32,589,688			4.00
5.01	01160	COMMUNICATIONS	1,068	1,068	193,413	196		5.01
5.02	00591	COVID	0	0	380,013	0	-2,825,356	5.02
5.04	00570	ADMITTING	138	138	189,961	2	0	5.04
5.05	00580	BUSINESS OFFICE	2,947	2,947	501,325	3	0	5.05
5.06	00590	OTHER ADMINISTRATIVE	38,653	38,653	6,314,822	59	0	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	18,512	18,512	1,219,685	3	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,273	2,273	0	1	0	8.00
9.00	00900	HOUSEKEEPING	2,203	2,203	858,516	1	0	9.00
10.00	01000	DIETARY	5,845	5,845	521,836	5	0	10.00
11.00	01100	CAFETERIA	2,523	2,523	172,859	3	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	665	665	1,143,712	10	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,682	10,682	168,940	3	220,030	14.00
15.00	01500	PHARMACY	1,212	1,212	748,517	2	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,570	1,570	443,974	7	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	384	384	143,889	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	27,383	27,383	7,803,705	15	0	30.00
31.00	03100	INTENSIVE CARE UNIT	6,374	6,374	1,612,943	5	0	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0	35.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	9,008	9,008	463,557	19	0	50.00
53.00	05300	ANESTHESIOLOGY	364	364	0	1	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,205	8,205	1,230,827	8	0	54.00
57.00	05700	CT SCAN	560	560	109,382	0	0	57.00
60.00	06000	LABORATORY	6,624	6,624	814,482	6	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,062	2,062	660,061	2	0	65.00
66.00	06600	PHYSICAL THERAPY	3,165	3,165	328,737	7	0	66.00
69.00	06900	ELECTROCARDIOLOGY	576	576	80,787	3	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	391	391	12,583	1	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES 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
75.01	07501	HYBERBARIC CHAMBER	0	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	6,873	6,873	216,714	2	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	177	177	66,651	1	0	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	0	90.01
90.02	09002	YMCA CLINIC	0	0	0	0	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	0	90.03
90.04	09004	CLINIC #4	0	0	0	0	0	90.04
90.05	09005	WOUND CARE	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	8,910	8,910	4,439,451	17	0	91.00
91.01	09101	GOLDEN LIFE	0	0	0	0	0	91.01
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
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	170,448	170,448	30,841,342	186	-2,605,326	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/30/2020 9:31 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (PHONES)	Reconciliation		
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)					
		1.00	2.00					4.00
	NONREIMBURSABLE COST CENTERS							
194.00	07950	PUBLIC RELATIONS	0	0	39,704	1	0	194.00
194.01	07952	RESEARCH	280	280	123,227	0	0	194.01
194.02	07953	OPMH	3,586	3,586	701,586	7	0	194.02
194.03	07954	CLINIC OTHER	2,349	2,349	883,829	0	0	194.03
194.10	07951	AUSTIN PRIDE	0	0	0	2	0	194.10
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)	2,510,454	353,310	4,030,067	390,762		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.210412	1.999909	0.123661	1,993.683673		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			17,848	17,419		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000548	88.872449		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: 14-0083

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/30/2020 9:31 am

Cost Center Description		COVID (ACCUM. COST)	ADMITTING (INPATIENT REVENUE)	BUSINESS OFFICE (GROSS REVE NUE)	Reconciliation	OTHER ADMINISTRATIVE (ACCUM. COST)	
		5.02	5.04	5.05	5A.06	5.06	
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
5.01	01160	COMMUNICATIONS					5.01
5.02	00591	COVID	64,144,192				5.02
5.04	00570	ADMITTING	252,684	52,904,042			5.04
5.05	00580	BUSINESS OFFICE	3,858,362	0	93,681,212		5.05
5.06	00590	OTHER ADMINISTRATIVE	16,898,272	0	0	-17,642,589	49,326,959
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	3,031,400	0	0	0	3,164,924
8.00	00800	LAUNDRY & LINEN SERVICE	118,029	0	0	0	123,228
9.00	00900	HOUSEKEEPING	1,595,600	0	0	0	1,665,881
10.00	01000	DIETARY	1,873,889	0	0	0	1,956,428
11.00	01100	CAFETERIA	531,147	0	0	0	554,542
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	1,557,413	0	0	0	1,626,012
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	220,030	0
15.00	01500	PHARMACY	1,427,335	0	0	0	1,490,205
16.00	01600	MEDICAL RECORDS & LIBRARY	782,989	0	0	0	817,477
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	393,206	0	0	0	410,526
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	10,141,250	23,970,930	36,807,128	0	12,290,192
31.00	03100	INTENSIVE CARE UNIT	2,086,702	4,302,200	4,302,200	0	2,385,065
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	689,044	1,099,230	2,295,234	0	823,571
53.00	05300	ANESTHESIOLOGY	7,895	96,245	222,523	0	18,291
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,823,191	986,852	2,939,572	0	3,078,867
57.00	05700	CT SCAN	162,212	745,491	2,586,545	0	284,296
60.00	06000	LABORATORY	3,316,417	5,214,781	10,431,709	0	3,937,064
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	876,412	2,781,496	3,834,455	0	1,093,768
66.00	06600	PHYSICAL THERAPY	500,475	388,519	836,523	0	560,427
69.00	06900	ELECTROCARDIOLOGY	138,411	962,694	1,410,761	0	209,972
70.00	07000	ELECTROENCEPHALOGRAPHY	23,698	12,461	12,903	0	25,359
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	587,269	812,053	2,304,046	0	716,260
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	657,520	6,685,625	8,679,367	0	1,093,036
74.00	07400	RENAL DIALYSIS	135,052	77,935	77,935	0	144,741
75.01	07501	HYPERBARIC CHAMBER	0	0	0	0	0
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	0
76.10	03950	PARTIAL HOSPITALIZATION	378,872	724	1,521,474	0	460,987
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	91,027	32,601	116,059	0	100,190
90.01	09001	CICERO CLINIC	0	0	0	0	0
90.02	09002	YMCA CLINIC	266	0	0	0	278
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	0
90.04	09004	CLINIC #4	0	0	0	0	0
90.05	09005	WOUND CARE	0	0	0	0	0
91.00	09100	EMERGENCY	5,735,511	4,734,205	15,302,778	0	6,669,771
91.01	09101	GOLDEN LIFE	0	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	60,671,550	52,904,042	93,681,212	-17,422,559	45,701,358
NONREIMBURSABLE COST CENTERS							
194.00	07950	PUBLIC RELATIONS	81,889	0	0	0	85,496
194.01	07952	RESEARCH	103,123	0	0	0	107,665

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/30/2020 9:31 am

Cost Center Description			COVID (ACCUM. COST)	ADMITTING (INPATIENT REVENUE)	BUSINESS OFFICE (GROSS REVE NUE)	Reconciliation	OTHER ADMINISTRATIVE (ACCUM. COST)	
			5.02	5.04	5.05	5A.06	5.06	
194.02	07953	OPMH	1,011,696	0	0	0	1,056,258	194.02
194.03	07954	CLINIC OTHER	2,271,947	0	0	0	2,372,019	194.03
194.10	07951	AUSTIN PRIDE	3,987	0	0	0	4,163	194.10
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)	2,825,356	263,814	4,028,311		17,642,589	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.044047	0.004987	0.043000		0.357666	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	208	2,520	48,326		690,085	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000003	0.000048	0.000516		0.013990	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: 14-0083

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY))	HOUSEKEEPING (HOURS OF S ERVICE))	DIETARY (MEALS SERV ED))	
			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
5.01	01160	COMMUNICATIONS						5.01
5.02	00591	COVID						5.02
5.04	00570	ADMITTING						5.04
5.05	00580	BUSINESS OFFICE						5.05
5.06	00590	OTHER ADMINISTRATIVE						5.06
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	114,244				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,273	257,967			8.00
9.00	00900	HOUSEKEEPING	0	2,203	0	33,479		9.00
10.00	01000	DIETARY	0	5,845	0	1,432	50,631	10.00
11.00	01100	CAFETERIA	0	2,523	0	474	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	665	0	1,594	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,682	0	450	0	14.00
15.00	01500	PHARMACY	0	1,212	0	855	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,570	0	968	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	384	0	280	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	27,383	168,395	11,663	48,807	30.00
31.00	03100	INTENSIVE CARE UNIT	0	6,374	12,273	1,536	1,824	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0	35.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	9,008	77,299	501	0	50.00
53.00	05300	ANESTHESIOLOGY	0	364	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,205	0	1,709	0	54.00
57.00	05700	CT SCAN	0	560	0	111	0	57.00
60.00	06000	LABORATORY	0	6,624	0	1,464	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	2,062	0	888	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,165	0	517	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	576	0	173	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	391	0	26	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES 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
75.01	07501	HYPERBARIC CHAMBER	0	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	0	6,873	0	935	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	177	0	106	0	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	0	90.01
90.02	09002	YMCA CLINIC	0	0	0	0	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	0	90.03
90.04	09004	CLINIC #4	0	0	0	0	0	90.04
90.05	09005	WOUND CARE	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	8,910	0	4,249	0	91.00
91.01	09101	GOLDEN LIFE	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	108,029	257,967	29,931	50,631	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	PUBLIC RELATIONS	0	0	0	70	0	194.00
194.01	07952	RESEARCH	0	280	0	199	0	194.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY))	HOUSEKEEPING (HOURS OF S ERVICE))	DIETARY (MEALS SERV ED))	
			6.00	7.00	8.00	9.00	10.00	
194.02	07953	OPMH	0	3,586	0	1,525	0	194.02
194.03	07954	CLINIC OTHER	0	2,349	0	1,754	0	194.03
194.10	07951	AUSTIN PRIDE	0	0	0	0	0	194.10
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	4,296,910	252,793	2,344,569	2,976,300	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	37.611691	0.979943	70.031034	58.784144	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	345,306	45,529	66,241	143,355	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	3.022531	0.176492	1.978584	2.831368	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: 14-0083

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAFETERIA (FTES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRS G HRS))	CENTRAL SERVICES & SUPPLY (COSTED REQ UIS))	PHARMACY (COSTED REQ UIS))	
			11.00	12.00	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
5.01	01160	COMMUNICATIONS						5.01
5.02	00591	COVID						5.02
5.04	00570	ADMITTING						5.04
5.05	00580	BUSINESS OFFICE						5.05
5.06	00590	OTHER ADMINISTRATIVE						5.06
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	31,573					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	1,594	0	374,786			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	450	0	0	1,449,605		14.00
15.00	01500	PHARMACY	855	0	0	1,781	812,256	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	968	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	280	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,663	0	243,533	205,491	2,671	30.00
31.00	03100	INTENSIVE CARE UNIT	1,536	0	32,070	10,068	89	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0	35.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	501	0	10,468	28,963	3,771	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,709	0	0	15,780	78	54.00
57.00	05700	CT SCAN	111	0	0	0	0	57.00
60.00	06000	LABORATORY	1,464	0	0	438,054	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	888	0	0	6,224	0	65.00
66.00	06600	PHYSICAL THERAPY	517	0	0	242	0	66.00
69.00	06900	ELECTROCARDIOLOGY	173	0	0	288	6	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	26	0	0	72	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	587,269	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	657,520	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.01	07501	HYPERBARIC CHAMBER	0	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	935	0	0	746	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	106	0	0	7,111	0	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	0	90.01
90.02	09002	YMCA CLINIC	0	0	0	0	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	0	90.03
90.04	09004	CLINIC #4	0	0	0	0	0	90.04
90.05	09005	WOUND CARE	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	4,249	0	88,715	80,873	28,715	91.00
91.01	09101	GOLDEN LIFE	0	0	0	0	0	91.01
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
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,025	0	374,786	1,382,962	692,850	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	PUBLIC RELATIONS	70	0	0	0	0	194.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/30/2020 9:31 am

Cost Center Description			CAFETERIA (FTES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRS G HRS))	CENTRAL SERVICES & SUPPLY (COSTED REQ UIS))	PHARMACY (COSTED REQ UIS))	
			11.00	12.00	13.00	14.00	15.00	
194.01	07952	RESEARCH	199	0	0	0	0	194.01
194.02	07953	OPMH	1,525	0	0	181	3,332	194.02
194.03	07954	CLINIC OTHER	1,754	0	0	66,462	116,074	194.03
194.10	07951	AUSTIN PRIDE	0	0	0	0	0	194.10
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)	880,972	0	2,388,699	225,808	2,152,797	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.902702	0.000000	6.373501	0.155772	2.650392	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	57,585	0	43,120	207,517	105,097	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.823868	0.000000	0.115052	0.050049	0.129389	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: 14-0083

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/30/2020 9:31 am

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED T IME))	
			16.00	17.00	19.00	20.00	21.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00591	COVID						5.02
5.04	00570	ADMITTING						5.04
5.05	00580	BUSINESS OFFICE						5.05
5.06	00590	OTHER ADMINISTRATIVE						5.06
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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	93,681,212					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			100	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	36,807,128	0	0	0	100	30.00
31.00	03100	INTENSIVE CARE UNIT	4,302,200	0	0	0	0	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0	35.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,295,234	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	222,523	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,939,572	0	0	0	0	54.00
57.00	05700	CT SCAN	2,586,545	0	0	0	0	57.00
60.00	06000	LABORATORY	10,431,709	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	3,834,455	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	836,523	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	1,410,761	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	12,903	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,304,046	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,679,367	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	77,935	0	0	0	0	74.00
75.01	07501	HYPERBARIC CHAMBER	0	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	1,521,474	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	116,059	0	0	0	0	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	0	90.01
90.02	09002	YMCA CLINIC	0	0	0	0	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	0	90.03
90.04	09004	CLINIC #4	0	0	0	0	0	90.04
90.05	09005	WOUND CARE	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	15,302,778	0	0	0	0	91.00
91.01	09101	GOLDEN LIFE	0	0	0	0	0	91.01
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
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	93,681,212	0	0	0	100	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/30/2020 9:31 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	SOCIAL SERVICE (TIME SPENT))	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED T IME))	
		16.00	17.00	19.00	20.00	21.00	
NONREIMBURSABLE COST CENTERS							
194.00	07950	PUBLIC RELATIONS	0	0	0	0	194.00
194.01	07952	RESEARCH	0	0	0	0	194.01
194.02	07953	OPMH	0	0	0	0	194.02
194.03	07954	CLINIC OTHER	0	0	0	0	194.03
194.10	07951	AUSTIN PRIDE	0	0	0	0	194.10
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)	1,263,711	0	0	599,222	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.013489	0.000000	0.000000	5,992.220000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	46,180	0	0	14,274	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000493	0.000000	0.000000	142.740000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
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		Cost Center Description	INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)		
			SERVICES-OTHER PRGM COSTS			
			APPRV (ASSIGNED T IME))			
			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
5.01	01160	COMMUNICATIONS				5.01
5.02	00591	COVID				5.02
5.04	00570	ADMITTING				5.04
5.05	00580	BUSINESS OFFICE				5.05
5.06	00590	OTHER ADMINISTRATIVE				5.06
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
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
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
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
20.00	02000	NURSING SCHOOL				20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0		35.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES 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
75.01	07501	HYBERBARIC CHAMBER	0	0		75.01
76.00	03550	O/P MENTAL HEALTH	0	0		76.00
76.10	03950	PARTIAL HOSPITALIZATION	0	0		76.10
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CICERO CLINIC	0	0		90.01
90.02	09002	YMCA CLINIC	0	0		90.02
90.03	09003	NORTH AVENUE CLINIC	0	0		90.03
90.04	09004	CLINIC #4	0	0		90.04
90.05	09005	WOUND CARE	0	0		90.05
91.00	09100	EMERGENCY	0	0		91.00
91.01	09101	GOLDEN LIFE	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0		99.40
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0		118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020Worksheet B-1
Date/Time Prepared:
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Cost Center Description		INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)		
		SERVICES-OTHER			
		PRGM COSTS APPRV (ASSIGNED T IME))			
		22.00			
NONREIMBURSABLE COST CENTERS					
194.00	07950	PUBLIC RELATIONS	0	0	194.00
194.01	07952	RESEARCH	0	0	194.01
194.02	07953	OPMH	0	0	194.02
194.03	07954	CLINIC OTHER	0	0	194.03
194.10	07951	AUSTIN PRIDE	0	0	194.10
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	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/30/2020 9:31 am

			Title XVIII		Hospital		PPS		
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs		
					Total Costs	RCE Disallowance			
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	23,979,988		23,979,988	0	23,979,988	30.00	
31.00	03100	INTENSIVE CARE UNIT	4,011,769		4,011,769	0	4,011,769	31.00	
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0		0	0	0	35.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,693,939		1,693,939	0	1,693,939	50.00	
53.00	05300	ANESTHESIOLOGY	41,526		41,526	0	41,526	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,698,363		4,698,363	0	4,698,363	54.00	
57.00	05700	CT SCAN	452,802		452,802	0	452,802	57.00	
60.00	06000	LABORATORY	5,946,683		5,946,683	0	5,946,683	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	1,702,186	0	1,702,186	0	1,702,186	65.00	
66.00	06600	PHYSICAL THERAPY	941,868	0	941,868	0	941,868	66.00	
69.00	06900	ELECTROCARDIOLOGY	342,769		342,769	0	342,769	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	51,866		51,866	0	51,866	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,095,000		1,095,000	0	1,095,000	71.00	
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0		0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	3,343,739		3,343,739	0	3,343,739	73.00	
74.00	07400	RENAL DIALYSIS	197,561		197,561	0	197,561	74.00	
75.01	07501	HYBERBARIC CHAMBER	0		0	0	0	75.01	
76.00	03550	O/P MENTAL HEALTH	0		0	0	0	76.00	
76.10	03950	PARTIAL HOSPITALIZATION	996,578		996,578	0	996,578	76.10	
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	155,737		155,737	0	155,737	90.00	
90.01	09001	CICERO CLINIC	0		0	0	0	90.01	
90.02	09002	YMCA CLINIC	377		377	0	377	90.02	
90.03	09003	NORTH AVENUE CLINIC	0		0	0	0	90.03	
90.04	09004	CLINIC #4	0		0	0	0	90.04	
90.05	09005	WOUND CARE	0		0	0	0	90.05	
91.00	09100	EMERGENCY	10,667,110		10,667,110	0	10,667,110	91.00	
91.01	09101	GOLDEN LIFE	0		0	0	0	91.01	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,774,695		1,774,695	0	1,774,695	92.00	
	OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0		0		0	99.10	
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0		0	99.20	
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0		0	99.30	
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0		0	99.40	
200.00		Subtotal (see instructions)	62,094,556	0	62,094,556	0	62,094,556	200.00	
201.00		Less Observation Beds	1,774,695		1,774,695		1,774,695	201.00	
202.00		Total (see instructions)	60,319,861	0	60,319,861	0	60,319,861	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/30/2020 9:31 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	23,970,930		23,970,930			30.00
31.00	03100	INTENSIVE CARE UNIT	4,302,200		4,302,200			31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0		0			35.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,099,230	1,196,004	2,295,234	0.738025	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	96,245	126,278	222,523	0.186614	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	986,852	1,952,720	2,939,572	1.598315	0.000000	54.00
57.00	05700	CT SCAN	745,491	1,841,054	2,586,545	0.175061	0.000000	57.00
60.00	06000	LABORATORY	5,214,781	5,216,928	10,431,709	0.570058	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	2,781,496	1,052,959	3,834,455	0.443919	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	388,519	448,004	836,523	1.125932	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	962,694	448,067	1,410,761	0.242967	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	12,461	442	12,903	4.019685	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	812,053	1,491,993	2,304,046	0.475251	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,685,625	1,993,742	8,679,367	0.385251	0.000000	73.00
74.00	07400	RENAL DIALYSIS	77,935	0	77,935	2.534946	0.000000	74.00
75.01	07501	HYBERBARIC CHAMBER	0	0	0	0.000000	0.000000	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0.000000	0.000000	76.00
76.10	03950	PARTIAL HOSPITALIZATION	724	1,520,750	1,521,474	0.655008	0.000000	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	32,601	83,458	116,059	1.341878	0.000000	90.00
90.01	09001	CICERO CLINIC	0	0	0	0.000000	0.000000	90.01
90.02	09002	YMCA CLINIC	0	0	0	0.000000	0.000000	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	CLINIC #4	0	0	0	0.000000	0.000000	90.04
90.05	09005	WOUND CARE	0	0	0	0.000000	0.000000	90.05
91.00	09100	EMERGENCY	4,734,205	10,568,573	15,302,778	0.697070	0.000000	91.00
91.01	09101	GOLDEN LIFE	0	0	0	0.000000	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	12,836,198	12,836,198	0.138257	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
200.00		Subtotal (see instructions)	52,904,042	40,777,170	93,681,212			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	52,904,042	40,777,170	93,681,212			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0083	Period: From 07/01/2019 To 06/30/2020	Worksheet C Part I Date/Time Prepared: 11/30/2020 9:31 am
			Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio		
			11.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT			35.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.738025		50.00
53.00	05300	ANESTHESIOLOGY	0.186614		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1.598315		54.00
57.00	05700	CT SCAN	0.175061		57.00
60.00	06000	LABORATORY	0.570058		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0.443919		65.00
66.00	06600	PHYSICAL THERAPY	1.125932		66.00
69.00	06900	ELECTROCARDIOLOGY	0.242967		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4.019685		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.475251		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.385251		73.00
74.00	07400	RENAL DIALYSIS	2.534946		74.00
75.01	07501	HYBERBARIC CHAMBER	0.000000		75.01
76.00	03550	O/P MENTAL HEALTH	0.000000		76.00
76.10	03950	PARTIAL HOSPITALIZATION	0.655008		76.10
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.341878		90.00
90.01	09001	CICERO CLINIC	0.000000		90.01
90.02	09002	YMCA CLINIC	0.000000		90.02
90.03	09003	NORTH AVENUE CLINIC	0.000000		90.03
90.04	09004	CLINIC #4	0.000000		90.04
90.05	09005	WOUND CARE	0.000000		90.05
91.00	09100	EMERGENCY	0.697070		91.00
91.01	09101	GOLDEN LIFE	0.000000		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.138257		92.00
	OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY			99.40
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: 14-0083

Period:
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			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	24,579,210		24,579,210	0
31.00	03100	INTENSIVE CARE UNIT	4,011,769		4,011,769	0
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0		0	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,693,939		1,693,939	0
53.00	05300	ANESTHESIOLOGY	41,526		41,526	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,698,363		4,698,363	0
57.00	05700	CT SCAN	452,802		452,802	0
60.00	06000	LABORATORY	5,946,683		5,946,683	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0
65.00	06500	RESPIRATORY THERAPY	1,702,186	0	1,702,186	0
66.00	06600	PHYSICAL THERAPY	941,868	0	941,868	0
69.00	06900	ELECTROCARDIOLOGY	342,769		342,769	0
70.00	07000	ELECTROENCEPHALOGRAPHY	51,866		51,866	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,095,000		1,095,000	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0		0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	3,343,739		3,343,739	0
74.00	07400	RENAL DIALYSIS	197,561		197,561	0
75.01	07501	HYPERBARIC CHAMBER	0		0	0
76.00	03550	O/P MENTAL HEALTH	0		0	0
76.10	03950	PARTIAL HOSPITALIZATION	996,578		996,578	0
76.97	07697	CARDIAC REHABILITATION	0		0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0
76.99	07699	LITHOTRIPSY	0		0	0
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	155,737		155,737	0
90.01	09001	CICERO CLINIC	0		0	0
90.02	09002	YMCA CLINIC	377		377	0
90.03	09003	NORTH AVENUE CLINIC	0		0	0
90.04	09004	CLINIC #4	0		0	0
90.05	09005	WOUND CARE	0		0	0
91.00	09100	EMERGENCY	10,667,110		10,667,110	0
91.01	09101	GOLDEN LIFE	0		0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,819,041		1,819,041	0
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0	0
200.00		Subtotal (see instructions)	62,738,124	0	62,738,124	0
201.00		Less Observation Beds	1,819,041		1,819,041	0
202.00		Total (see instructions)	60,919,083	0	60,919,083	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0083

Period:
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			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	0		0			30.00	
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00	
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0		0			35.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00	
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00	
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000	66.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00	
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00	
75.01	07501	HYBERBARIC CHAMBER	0	0	0	0.000000	0.000000	75.01	
76.00	03550	O/P MENTAL HEALTH	0	0	0	0.000000	0.000000	76.00	
76.10	03950	PARTIAL HOSPITALIZATION	0	0	0	0.000000	0.000000	76.10	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98	
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00	
90.01	09001	CICERO CLINIC	0	0	0	0.000000	0.000000	90.01	
90.02	09002	YMCA CLINIC	0	0	0	0.000000	0.000000	90.02	
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0.000000	0.000000	90.03	
90.04	09004	CLINIC #4	0	0	0	0.000000	0.000000	90.04	
90.05	09005	WOUND CARE	0	0	0	0.000000	0.000000	90.05	
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00	
91.01	09101	GOLDEN LIFE	0	0	0	0.000000	0.000000	91.01	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00	
	OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0			99.10	
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20	
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30	
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40	
200.00		Subtotal (see instructions)	0	0	0			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	0	0	0			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0083

Period:
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Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT				35.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
57.00	05700	CT SCAN	0.000000			57.00
60.00	06000	LABORATORY	0.000000			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPLANTABLE DEVICES 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
75.01	07501	HYPERBARIC CHAMBER	0.000000			75.01
76.00	03550	O/P MENTAL HEALTH	0.000000			76.00
76.10	03950	PARTIAL HOSPITALIZATION	0.000000			76.10
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
90.01	09001	CICERO CLINIC	0.000000			90.01
90.02	09002	YMCA CLINIC	0.000000			90.02
90.03	09003	NORTH AVENUE CLINIC	0.000000			90.03
90.04	09004	CLINIC #4	0.000000			90.04
90.05	09005	WOUND CARE	0.000000			90.05
91.00	09100	EMERGENCY	0.000000			91.00
91.01	09101	GOLDEN LIFE	0.000000			91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
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: 14-0083

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part I
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			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	994,287	0	994,287	19,417	51.21	30.00
31.00	INTENSIVE CARE UNIT	179,215		179,215	849	211.09	31.00
35.00	DETOXIFICATION INTENSIVE CARE UNIT	0		0	0	0.00	35.00
200.00	Total (lines 30 through 199)	1,173,502		1,173,502	20,266		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	3,222	164,999				30.00
31.00	INTENSIVE CARE UNIT	473	99,846				31.00
35.00	DETOXIFICATION INTENSIVE CARE UNIT	0	0				35.00
200.00	Total (lines 30 through 199)	3,695	264,845				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part II
Date/Time Prepared:
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				Title XVIII		Hospital	PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	207,775	2,295,234	0.090525	487,033	44,089	50.00
53.00	05300	ANESTHESIOLOGY	7,576	222,523	0.034046	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	213,202	2,939,572	0.072528	272,080	19,733	54.00
57.00	05700	CT SCAN	17,876	2,586,545	0.006911	189,415	1,309	57.00
60.00	06000	LABORATORY	221,734	10,431,709	0.021256	1,042,670	22,163	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	73,387	3,834,455	0.019139	925,839	17,720	65.00
66.00	06600	PHYSICAL THERAPY	72,357	836,523	0.086497	132,405	11,453	66.00
69.00	06900	ELECTROCARDIOLOGY	16,470	1,410,761	0.011675	326,376	3,810	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,087	12,903	0.626753	2,173	1,362	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	41,778	2,304,046	0.018132	180,983	3,282	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	109,448	8,679,367	0.012610	1,700,144	21,439	73.00
74.00	07400	RENAL DIALYSIS	2,107	77,935	0.027035	17,160	464	74.00
75.01	07501	HYBERBARIC CHAMBER	0	0	0.000000	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0.000000	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	144,061	1,521,474	0.094685	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	21,099	116,059	0.181795	3,948	718	90.00
90.01	09001	CICERO CLINIC	0	0	0.000000	0	0	90.01
90.02	09002	YMCA CLINIC	4	0	0.000000	0	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	CLINIC #4	0	0	0.000000	0	0	90.04
90.05	09005	WOUND CARE	0	0	0.000000	0	0	90.05
91.00	09100	EMERGENCY	318,430	15,302,778	0.020809	802,818	16,706	91.00
91.01	09101	GOLDEN LIFE	0	0	0.000000	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	73,584	12,836,198	0.005733	0	0	92.00
200.00		Total (lines 50 through 199)	1,548,975	65,408,082		6,083,044	164,248	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0083		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part III Date/Time Prepared: 11/30/2020 9:31 am	
					Title XVIII		Hospital		PPS	
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT		0	0	0	0	0	0	35.00
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	19,417	0.00	3,222		30.00
31.00	03100	INTENSIVE CARE UNIT			0	849	0.00	473		31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT			0	0	0.00	0		35.00
200.00		Total (lines 30 through 199)			0	20,266		3,695		200.00
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
					9.00					
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0						30.00
31.00	03100	INTENSIVE CARE UNIT		0						31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT		0						35.00
200.00		Total (lines 30 through 199)		0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
11/30/2020 9:31 am

Cost Center Description			Title XVIII		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES 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
75.01	07501	HYPERBARIC CHAMBER	0	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	0	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	0	90.01
90.02	09002	YMCA CLINIC	0	0	0	0	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	0	90.03
90.04	09004	CLINIC #4	0	0	0	0	0	90.04
90.05	09005	WOUND CARE	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	09101	GOLDEN LIFE	0	0	0	0	0	91.01
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: 14-0083		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 11/30/2020 9:31 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	2,295,234	0.000000	50.00
53.00	05300	ANESTHESIOLOGY		0	0	0	222,523	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	2,939,572	0.000000	54.00
57.00	05700	CT SCAN		0	0	0	2,586,545	0.000000	57.00
60.00	06000	LABORATORY		0	0	0	10,431,709	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY		0	0	0	3,834,455	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	836,523	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	1,410,761	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	12,903	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	2,304,046	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS		0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	8,679,367	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	77,935	0.000000	74.00
75.01	07501	HYPERBARIC CHAMBER		0	0	0	0	0.000000	75.01
76.00	03550	O/P MENTAL HEALTH		0	0	0	0	0.000000	76.00
76.10	03950	PARTIAL HOSPITALIZATION		0	0	0	1,521,474	0.000000	76.10
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	116,059	0.000000	90.00
90.01	09001	CICERO CLINIC		0	0	0	0	0.000000	90.01
90.02	09002	YMCA CLINIC		0	0	0	0	0.000000	90.02
90.03	09003	NORTH AVENUE CLINIC		0	0	0	0	0.000000	90.03
90.04	09004	CLINIC #4		0	0	0	0	0.000000	90.04
90.05	09005	WOUND CARE		0	0	0	0	0.000000	90.05
91.00	09100	EMERGENCY		0	0	0	15,302,778	0.000000	91.00
91.01	09101	GOLDEN LIFE		0	0	0	0	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	12,836,198	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	65,408,082		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
11/30/2020 9:31 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	487,033	0	193,802	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	272,080	0	219,210	0	54.00
57.00	05700	CT SCAN	0.000000	189,415	0	184,441	0	57.00
60.00	06000	LABORATORY	0.000000	1,042,670	0	290,287	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	925,839	0	99,715	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	132,405	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	326,376	0	96,808	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	2,173	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	180,983	0	113,536	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,700,144	0	183,396	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	17,160	0	0	0	74.00
75.01	07501	HYPERBARIC CHAMBER	0.000000	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0.000000	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	0.000000	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	3,948	0	41,426	0	90.00
90.01	09001	CICERO CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	YMCA CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	CLINIC #4	0.000000	0	0	0	0	90.04
90.05	09005	WOUND CARE	0.000000	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.000000	802,818	0	714,997	0	91.00
91.01	09101	GOLDEN LIFE	0.000000	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	705,600	0	92.00
200.00		Total (lines 50 through 199)		6,083,044	0	2,843,218	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
11/30/2020 9:31 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	0.738025	193,802	0	0	143,031	50.00
53.00	05300	ANESTHESIOLOGY	0.186614	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1.598315	219,210	0	0	350,367	54.00
57.00	05700	CT SCAN	0.175061	184,441	0	0	32,288	57.00
60.00	06000	LABORATORY	0.570058	290,287	0	0	165,480	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.443919	99,715	0	0	44,265	65.00
66.00	06600	PHYSICAL THERAPY	1.125932	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.242967	96,808	0	0	23,521	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4.019685	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.475251	113,536	0	0	53,958	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.385251	183,396	0	1,042	70,653	73.00
74.00	07400	RENAL DIALYSIS	2.534946	0	0	0	0	74.00
75.01	07501	HYBERBARIC CHAMBER	0.000000	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0.000000	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	0.655008	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1.341878	41,426	0	0	55,589	90.00
90.01	09001	CICERO CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	YMCA CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	CLINIC #4	0.000000	0	0	0	0	90.04
90.05	09005	WOUND CARE	0.000000	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.697070	714,997	0	0	498,403	91.00
91.01	09101	GOLDEN LIFE	0.000000	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.138257	705,600	0	0	97,554	92.00
200.00		Subtotal (see instructions)		2,843,218	0	1,042	1,535,109	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		2,843,218	0	1,042	1,535,109	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0083		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part V Date/Time Prepared: 11/30/2020 9:31 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
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
57.00	05700	CT SCAN	0	0					57.00
60.00	06000	LABORATORY	0	0					60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0					62.30
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0					70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0					71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	401					73.00
74.00	07400	RENAL DIALYSIS	0	0					74.00
75.01	07501	HYBERBARIC CHAMBER	0	0					75.01
76.00	03550	O/P MENTAL HEALTH	0	0					76.00
76.10	03950	PARTIAL HOSPITALIZATION	0	0					76.10
76.97	07697	CARDIAC REHABILITATION	0	0					76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0					76.98
76.99	07699	LITHOTRIPSY	0	0					76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0					90.00
90.01	09001	CICERO CLINIC	0	0					90.01
90.02	09002	YMCA CLINIC	0	0					90.02
90.03	09003	NORTH AVENUE CLINIC	0	0					90.03
90.04	09004	CLINIC #4	0	0					90.04
90.05	09005	WOUND CARE	0	0					90.05
91.00	09100	EMERGENCY	0	0					91.00
91.01	09101	GOLDEN LIFE	0	0					91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					92.00
200.00		Subtotal (see instructions)	0	401					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	401					202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part I
Date/Time Prepared:
11/30/2020 9:31 am

			Title XIX		Hospital	Cost	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	994,287	0	994,287	19,417	51.21	30.00
31.00	INTENSIVE CARE UNIT	179,215		179,215	849	211.09	31.00
35.00	DETOXIFICATION INTENSIVE CARE UNIT	0		0	0	0.00	35.00
200.00	Total (lines 30 through 199)	1,173,502		1,173,502	20,266		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	2,506	128,332				
31.00	INTENSIVE CARE UNIT	78	16,465				
35.00	DETOXIFICATION INTENSIVE CARE UNIT	0	0				
200.00	Total (lines 30 through 199)	2,584	144,797				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part II
Date/Time Prepared:
11/30/2020 9:31 am

Cost Center Description		Title XIX		Hospital		Cost	
		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	207,775	0	0.000000	0	50.00
53.00	05300	ANESTHESIOLOGY	7,576	0	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	213,202	0	0.000000	0	54.00
57.00	05700	CT SCAN	17,876	0	0.000000	0	57.00
60.00	06000	LABORATORY	221,734	0	0.000000	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	73,387	0	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	72,357	0	0.000000	0	66.00
69.00	06900	ELECTROCARDIOLOGY	16,470	0	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,087	0	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	41,778	0	0.000000	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	109,448	0	0.000000	0	73.00
74.00	07400	RENAL DIALYSIS	2,107	0	0.000000	0	74.00
75.01	07501	HYPERBARIC CHAMBER	0	0	0.000000	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0.000000	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	144,061	0	0.000000	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	21,099	0	0.000000	0	90.00
90.01	09001	CICERO CLINIC	0	0	0.000000	0	90.01
90.02	09002	YMCA CLINIC	4	0	0.000000	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0.000000	0	90.03
90.04	09004	CLINIC #4	0	0	0.000000	0	90.04
90.05	09005	WOUND CARE	0	0	0.000000	0	90.05
91.00	09100	EMERGENCY	318,430	0	0.000000	0	91.00
91.01	09101	GOLDEN LIFE	0	0	0.000000	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	73,584	0	0.000000	0	92.00
200.00		Total (lines 50 through 199)	1,548,975	0		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS						Provider CCN: 14-0083		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part III Date/Time Prepared: 11/30/2020 9:31 am		
						Title XIX		Hospital		Cost		
Cost Center Description						Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
						1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS												
30.00	03000	ADULTS & PEDIATRICS		0	0		0		0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	0		0		0	0	31.00	
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT		0	0		0		0	0	35.00	
200.00		Total (lines 30 through 199)		0	0		0		0	0	200.00	
Cost Center Description						Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
						4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS												
30.00	03000	ADULTS & PEDIATRICS		0	0		19,417		0.00	2,506	30.00	
31.00	03100	INTENSIVE CARE UNIT			0		849		0.00	78	31.00	
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT			0		0		0.00	0	35.00	
200.00		Total (lines 30 through 199)			0		20,266			2,584	200.00	
Cost Center Description						Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
						9.00						
INPATIENT ROUTINE SERVICE COST CENTERS												
30.00	03000	ADULTS & PEDIATRICS		0							30.00	
31.00	03100	INTENSIVE CARE UNIT		0							31.00	
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT		0							35.00	
200.00		Total (lines 30 through 199)		0							200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
11/30/2020 9:31 am

Cost Center Description			Title XIX		Hospital		Cost	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES 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
75.01	07501	HYPERBARIC CHAMBER	0	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	0	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	0	90.01
90.02	09002	YMCA CLINIC	0	0	0	0	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	0	90.03
90.04	09004	CLINIC #4	0	0	0	0	0	90.04
90.05	09005	WOUND CARE	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	09101	GOLDEN LIFE	0	0	0	0	0	91.01
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: 14-0083

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
11/30/2020 9:31 am

Cost Center Description			Title XIX		Hospital		Cost	
			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	0	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
60.00	06000	LABORATORY	0	0	0	0	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
75.01	07501	HYPERBARIC CHAMBER	0	0	0	0	0.000000	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	0.000000	76.00
76.10	03950	PARTIAL HOSPITALIZATION	0	0	0	0	0.000000	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	0.000000	90.01
90.02	09002	YMCA CLINIC	0	0	0	0	0.000000	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	CLINIC #4	0	0	0	0	0.000000	90.04
90.05	09005	WOUND CARE	0	0	0	0	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
91.01	09101	GOLDEN LIFE	0	0	0	0	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
11/30/2020 9:31 am

Cost Center Description		Title XIX		Hospital		Cost	
		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	0	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
60.00	06000 LABORATORY	0.000000	0	0	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.01	07501 HYPERBARIC CHAMBER	0.000000	0	0	0	0	75.01
76.00	03550 O/P MENTAL HEALTH	0.000000	0	0	0	0	76.00
76.10	03950 PARTIAL HOSPITALIZATION	0.000000	0	0	0	0	76.10
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	09001 CICERO CLINIC	0.000000	0	0	0	0	90.01
90.02	09002 YMCA CLINIC	0.000000	0	0	0	0	90.02
90.03	09003 NORTH AVENUE CLINIC	0.000000	0	0	0	0	90.03
90.04	09004 CLINIC #4	0.000000	0	0	0	0	90.04
90.05	09005 WOUND CARE	0.000000	0	0	0	0	90.05
91.00	09100 EMERGENCY	0.000000	0	0	0	0	91.00
91.01	09101 GOLDEN LIFE	0.000000	0	0	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00	Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0083	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/30/2020 9:31 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)		19,417	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		19,417	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)		17,980	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)		3,222	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)		23,979,988	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)		23,979,988	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)		23,979,988	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,235.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,979,170	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)		3,979,170	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020

Worksheet D-1

Date/Time Prepared:
11/30/2020 9:31 am

Cost Center Description		Title XVIII		Hospital		PPS
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)					42.00
	Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT	4,011,769	849	4,725.29	473	2,235,062
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0.00	0	0
	Cost Center Description					
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,419,377
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					9,633,609
	PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					264,845
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					164,248
52.00	Total Program excludable cost (sum of lines 50 and 51)					429,093
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					9,204,516
	TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
	PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)					1,437
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,235.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,774,695

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020

Worksheet D-1

Date/Time Prepared:
11/30/2020 9:31 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	994,287	23,979,988	0.041463	1,774,695	73,584	90.00
91.00 Nursing School cost	0	23,979,988	0.000000	1,774,695	0	91.00
92.00 Allied health cost	0	23,979,988	0.000000	1,774,695	0	92.00
93.00 All other Medical Education	0	23,979,988	0.000000	1,774,695	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0083	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/30/2020 9:31 am
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		19,417	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		19,417	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)		17,980	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)		2,506	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)		24,579,210	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)		24,579,210	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)		24,579,210	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,265.86	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,172,245	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)		3,172,245	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020

Worksheet D-1

Date/Time Prepared:
11/30/2020 9:31 am

Cost Center Description		Title XIX		Hospital		Cost
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,011,769	849	4,725.29	78	368,573
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0.00	0	0
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,540,818
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					1,437
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,265.86
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,819,041

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020

Worksheet D-1

Date/Time Prepared:
11/30/2020 9:31 am

		Title XIX		Hospital	Cost	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	994,287	24,579,210	0.040452	1,819,041	73,584	90.00
91.00 Nursing School cost	0	24,579,210	0.000000	1,819,041	0	91.00
92.00 Allied health cost	0	24,579,210	0.000000	1,819,041	0	92.00
93.00 All other Medical Education	0	24,579,210	0.000000	1,819,041	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0083	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 11/30/2020 9:31 am	
Cost Center Description		Title XVIII	Hospital	PPS	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		4,253,511	30.00
31.00	03100	INTENSIVE CARE UNIT		1,158,850	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT		0	35.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.738025	487,033	50.00
53.00	05300	ANESTHESIOLOGY	0.186614	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1.598315	272,080	54.00
57.00	05700	CT SCAN	0.175061	189,415	57.00
60.00	06000	LABORATORY	0.570058	1,042,670	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.443919	925,839	65.00
66.00	06600	PHYSICAL THERAPY	1.125932	132,405	66.00
69.00	06900	ELECTROCARDIOLOGY	0.242967	326,376	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4.019685	2,173	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.475251	180,983	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.385251	1,700,144	73.00
74.00	07400	RENAL DIALYSIS	2.534946	17,160	74.00
75.01	07501	HYPERBARIC CHAMBER	0.000000	0	75.01
76.00	03550	O/P MENTAL HEALTH	0.000000	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	0.655008	0	76.10
76.97	07697	CARDIAC REHABILITATION	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1.341878	3,948	90.00
90.01	09001	CICERO CLINIC	0.000000	0	90.01
90.02	09002	YMCA CLINIC	0.000000	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0.000000	0	90.03
90.04	09004	CLINIC #4	0.000000	0	90.04
90.05	09005	WOUND CARE	0.000000	0	90.05
91.00	09100	EMERGENCY	0.697070	802,818	91.00
91.01	09101	GOLDEN LIFE	0.000000	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.138257	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		6,083,044	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)		6,083,044	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0083	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 11/30/2020 9:31 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)		1,305,799	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		3,506,546	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)		28,642	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		150,065	2.04
3.00	Managed Care Simulated Payments		2,324,001	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		118.07	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)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		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)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		2.07	11.00
12.00	Current year allowable FTE (see instructions)		2.07	12.00
13.00	Total allowable FTE count for the prior year.		2.00	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.		1.66	14.00
15.00	Sum of lines 12 through 14 divided by 3.		1.91	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		1.91	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.016177	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.016844	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.016177	21.00
22.00	IME payment adjustment (see instructions)		42,358	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		20,456	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)		0.00	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)		42,358	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		20,456	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		25.44	30.00
31.00	Percentage of Medicaid patient days (see instructions)		61.80	31.00
32.00	Sum of lines 30 and 31		87.24	32.00
33.00	Allowable disproportionate share percentage (see instructions)		61.19	33.00
34.00	Disproportionate share adjustment (see instructions)		736,169	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0083	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 11/30/2020 9:31 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)	1,803,173	1,264,298	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	454,499	946,496	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,400,995		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
			Before 1/1	On/After 1/1
			1.00	1.01
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0 41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0 41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	7,170,574		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)		7,191,030	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		467,239	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).		46,919	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)		7,705,188	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		7,705,188	61.00
62.00	Deductibles billed to program beneficiaries		454,916	62.00
63.00	Coinsurance billed to program beneficiaries		84,821	63.00
64.00	Allowable bad debts (see instructions)		467,092	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		303,610	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		295,307	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		7,469,061	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		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)		-5,069	70.93
70.94	HRR adjustment amount (see instructions)		-6,311	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0083	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 11/30/2020 9:31 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)		76,469	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		7,381,212	71.00
71.01	Sequestration adjustment (see instructions)		123,266	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		7,139,323	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)		118,623	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		170,107	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

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/30/2020 9:31 am

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	1,305,799	1,305,799		1,305,799	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,506,546		3,506,546	3,506,546	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	28,642	28,642		28,642	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	150,065		150,065	150,065	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	2,324,001	500,614	1,823,387	2,324,001	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.016177	0.016177	0.016177		5.00
6.00	IME payment adjustment (see instructions)	22.00	42,358	11,494	30,864	42,358	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	20,456	4,406	16,050	20,456	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	42,358	11,494	30,864	42,358	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	20,456	4,406	16,050	20,456	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.6119	0.6119	0.6119		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	736,169	199,755	536,414	736,169	11.00
11.01	Uncompensated care payments	36.00	1,400,995	454,499	946,496	1,400,995	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	7,170,574	2,000,189	5,170,385	7,170,574	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	7,191,030	2,004,595	5,186,435	7,191,030	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	467,239	128,928	338,311	467,239	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			2,133,523	5,524,746	7,658,269	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/30/2020 9:31 am

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	382,498	106,232	276,266	382,498	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	6,750	1,035	5,715	6,750	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0106	0.0106	0.0106		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	4,054	1,126	2,928	4,054	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1933	0.1933	0.1933		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	73,937	20,535	53,402	73,937	25.00
26.00	Total prospective capital payments (see instructions)	12.00	467,239	128,928	338,311	467,239	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-5,069	-5,069	0	-5,069	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-6,311	0	-6,311	-6,311	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		21,285	55,184	76,469	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0083	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 11/30/2020 9:31 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		401	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		1,535,109	2.00
3.00	OPPS payments		643,628	3.00
4.00	Outlier payment (see instructions)		126,673	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)		401	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		1,042	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)		1,042	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)		1,042	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		641	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)		401	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)		770,301	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)		136,970	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)		633,732	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		7,479	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)		641,211	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		641,211	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)		99,191	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		64,474	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		58,248	36.00
37.00	Subtotal (see instructions)		705,685	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)		705,685	40.00
40.01	Sequestration adjustment (see instructions)		11,785	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		701,146	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)		-7,246	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: 14-0083

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part I
Date/Time Prepared:
11/30/2020 9:31 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		7,139,323		701,146	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		7,139,323		701,146	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		118,623		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		7,246	6.02
7.00	Total Medicare program liability (see instructions)		7,257,946		693,900	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

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020Worksheet E-3
Part VII
Date/Time Prepared:
11/30/2020 9:31 am

		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		3,540,818		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		3,540,818	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		3,540,818	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		3,540,818	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		3,540,818	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0083		Period: From 07/01/2019 To 06/30/2020	Worksheet E-4 Date/Time Prepared: 11/30/2020 9:31 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.					1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)					2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA					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)					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))					4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)					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)					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)					5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)					6.00
7.00	Enter the lesser of line 5 or line 6					7.00
		Primary Care	Other	Total		
		1.00	2.00	3.00		
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	0.00	0.00		8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	0.00	0.00		9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		2.07			10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00			10.01
11.00	Total weighted FTE count	0.00	2.07			11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	2.00			12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	1.66			13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	1.91			14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00			15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00			15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00			16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00			16.01
17.00	Adjusted rolling average FTE count	0.00	1.91			17.00
18.00	Per resident amount	103,540.56	103,540.56			18.00
19.00	Approved amount for resident costs	0	197,762	197,762		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)			197,762		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)	3,695	357	1,239	26.00	
27.00	Total Inpatient Days (see instructions)	18,829	18,829	18,829	27.00	
28.00	Ratio of inpatient days to total inpatient days	0.196240	0.018960	0.065803	28.00	
29.00	Program direct GME amount	38,809	3,750	13,013	55,572	29.00
29.01	Percent reduction for MA DGME		7.00	7.00		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		263	911	1,174	30.00
31.00	Net Program direct GME amount				54,398	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0083	Period: From 07/01/2019 To 06/30/2020	Worksheet E-4 Date/Time Prepared: 11/30/2020 9:31 am	
		Title XVIII	Hospital	PPS	
				1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			77,935	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)			9,633,609	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)			9,633,609	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			1,535,510	42.00
43.00	Primary payer payments (see instructions)			0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			1,535,510	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			11,169,119	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.862522	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.137478	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			54,398	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			46,919	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			7,479	50.00

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

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020

Worksheet G

Date/Time Prepared:
11/30/2020 9:31 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	2,631,938	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	87,934,995	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-76,044,266	0	0	0	6.00
7.00	Inventory	1,241,268	0	0	0	7.00
8.00	Prepaid expenses	105,617	0	0	0	8.00
9.00	Other current assets	3,814,345	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)	19,683,897	0	0	0	11.00
FIXED ASSETS						
12.00	Land	429,028	0	0	0	12.00
13.00	Land improvements	52,143	0	0	0	13.00
14.00	Accumulated depreciation	-40,418	0	0	0	14.00
15.00	Buildings	41,741,022	0	0	0	15.00
16.00	Accumulated depreciation	-25,289,448	0	0	0	16.00
17.00	Leasehold improvements	83,192	0	0	0	17.00
18.00	Accumulated depreciation	-83,192	0	0	0	18.00
19.00	Fixed equipment	11,547,794	0	0	0	19.00
20.00	Accumulated depreciation	-9,476,541	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	18,963,580	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	540,774	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	540,774	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	39,188,251	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	4,790,834	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,720,040	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,510,874	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	20,645,955	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	20,645,955	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	28,156,829	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	11,031,422				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	11,031,422	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	39,188,251	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020

Worksheet G-1

Date/Time Prepared:
11/30/2020 9:31 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		21,077,341		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-4,924,664				2.00
3.00	Total (sum of line 1 and line 2)		16,152,677		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	NET ASSETS RELEASED	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)		16,152,677		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	NET ASSETS	0		0		0	13.00
14.00	OTHER	5,121,255		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)		5,121,255		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		11,031,422		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	NET ASSETS RELEASED		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	Deductions (debit adjustments) (specify)		0				12.00
13.00	NET ASSETS		0				13.00
14.00	OTHER		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: 14-0083

Period:
From 07/01/2019
To 06/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
11/30/2020 9:31 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	25,003,586		25,003,586	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)	25,003,586		25,003,586	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	4,402,025		4,402,025	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	DETOXIFICATION INTENSIVE CARE UNIT	0		0	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	4,402,025		4,402,025	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	29,405,611		29,405,611	17.00
18.00	Ancillary services	24,250,853		24,250,853	18.00
19.00	Outpatient services	0	40,111,845	40,111,845	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
24.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24.20
24.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.30
24.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEE	0	7,120,155	7,120,155	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	53,656,464	47,232,000	100,888,464	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		73,551,226		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	BAD DEBTS	1,386,458			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)		1,386,458		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)		74,937,684		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0083

Period:
From 07/01/2019
To 06/30/2020

Worksheet G-3

Date/Time Prepared:
11/30/2020 9:31 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	100,888,464	1.00
2.00	Less contractual allowances and discounts on patients' accounts	62,995,460	2.00
3.00	Net patient revenues (line 1 minus line 2)	37,893,004	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	74,937,684	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-37,044,680	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	101,774	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	3,152	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	8,080	22.00
23.00	Governmental appropriations	5,824,689	23.00
24.00	OTHER INCOME	0	24.00
24.01	OTHER MISC	25,711,572	24.01
24.50	COVID-19 PHE Funding	470,749	24.50
25.00	Total other income (sum of lines 6-24)	32,120,016	25.00
26.00	Total (line 5 plus line 25)	-4,924,664	26.00
27.00	CLEARING	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)	-4,924,664	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0083	Period: From 07/01/2019 To 06/30/2020	Worksheet L Parts I-III Date/Time Prepared: 11/30/2020 9:31 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		382,498	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		6,750	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)		51.45	3.00
4.00	Number of interns & residents (see instructions)		1.91	4.00
5.00	Indirect medical education percentage (see instructions)		1.06	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		4,054	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		25.44	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		61.80	8.00
9.00	Sum of lines 7 and 8		87.24	9.00
10.00	Allowable disproportionate share percentage (see instructions)		19.33	10.00
11.00	Disproportionate share adjustment (see instructions)		73,937	11.00
12.00	Total prospective capital payments (see instructions)		467,239	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