

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 07/01/2020
To 06/30/2021Worksheet S
Parts I-III
Date/Time Prepared:
11/24/2021 9:09 am

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 11/24/2021	Time: 9:09 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	6. Date Received:	10. NPR Date:
	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
	(2) Settled without Audit	8. ☒ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4: Enter
	(3) Settled with Audit	9. ☒ Final Report for this Provider CCN	number of times reopened = 0-9.
	(4) Reopened		
	(5) Amended		

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 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

☐ 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	303,168	-14,781	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	303,168	-14,781	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.

Health Financial Systems		LORETTO HOSPITAL		In Lieu of Form CMS-2552-10						
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0083		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/24/2021 9:09 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		2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		LORETTO HOSPITAL	140083	16974	1	07/01/1966	N	P	O
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF									
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC									
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
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)					07/01/2020	06/30/2021		20.00	
21.00	Type of Control (see instructions)					2			21.00	
						1.00	2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				Y	N			22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				Y	Y			22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				N	N			22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				N	N	N		22.03	
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMBdelineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.								22.04	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.				1	N			23.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/24/2021 9:09 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,162	441	0	0	11,335	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
						Urban/Rural S	Date of Geogr	
						1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
						Beginning:	Ending:	
						1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
						Y/N	Y/N	
						1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					Y	N	40.00
						V	XVIII	XIX
						1.00	2.00	3.00
	Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	Y	N
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
	Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					Y	Y	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					Y	Y	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/24/2021 9:09 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	
		1.00	2.00	3.00	4.00
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
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)				0.00
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)				0.00
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)				0.00
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).				0.00
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)				0.00
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)				0.00
		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
61.20	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
					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
62.01	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
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

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			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

Health Financial Systems		LORETTO HOSPITAL		In Lieu of Form CMS-2552-10	
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			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0083		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/24/2021 9:09 am	
				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N			108.00
				Physical	Occupational	Speech	Respiratory
				1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.						109.00
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N			110.00
				1.00	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
<u>Miscellaneous Cost Reporting Information</u>							
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:			1,966,667	0	0	118.01
				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
<u>Transplant Center Information</u>							
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0083	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/24/2021 9:09 am				
		1.00	2.00					
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				
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?				144.00			
				Y				
		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 1.00	Part B 2.00	Title V 3.00	Title XIX 4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	157.00		
158.00	SUBPROVIDER					158.00		
159.00	SNF	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00		
161.00	CMHC		N	N	N	161.00		
161.10	CORF		N	N	N	161.10		
161.20	OUTPATIENT PHYSICAL THERAPY		N	N	N	161.20		
161.30	OUTPATIENT OCCUPATIONAL THERAPY		N	N	N	161.30		
161.40	OUTPATIENT SPEECH PATHOLOGY		N	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 0	County 1.00	State 2.00	Zip Code 3.00	CBSA 4.00	FTE/Campus 5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0083	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/24/2021 9:09 am
				1.00
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act				
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)		9.99	169.00
		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part II
Date/Time Prepared:
11/24/2021 9:09 am

		Y/N	Date	
		1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	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	Legal Oper.	
		1.00	2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	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.	Y		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
		Y/N		
		1.00		
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N	Date	Y/N
		1.00	2.00	3.00
		4.00		
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/27/2021	Y
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

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Period:
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		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:
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Part II
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		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/24/2021 9:09 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	40,150	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	40,150	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,380	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	44,530	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 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/24/2021 9:09 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)	3,360	1,559	19,048			1.00
2.00	HMO and other (see instructions)	1,938	11,335				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)	3,360	1,559	19,048			7.00
8.00	INTENSIVE CARE UNIT	446	44	985			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)	3,806	1,603	20,033	4.24	440.80	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)				4.24	440.80	27.00
28.00	Observation Bed Days		0	2,089			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 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/24/2021 9:09 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	522	331	4,002	1.00
2.00 HMO and other (see instructions)			360	2,462		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	522	331	4,002	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 07/01/2020
To 06/30/2021Worksheet S-3
Part II
Date/Time Prepared:
11/24/2021 9:09 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	32,616,596	0	32,616,596	914,270.69	35.67
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	54,104	178,873	232,977	10,728.00	21.72
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)		1,965,941	0	1,965,941	61,316.58	32.06
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		280,923	0	280,923	2,080.00	135.06
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)		5,573,091	0	5,573,091		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		427,884	0	427,884		
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)		68,346	0	68,346		
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 07/01/2020
To 06/30/2021Worksheet S-3
Part II
Date/Time Prepared:
11/24/2021 9:09 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	440,887	0	440,887	11,128.00	39.62	26.00
27.00	Administrative & General	5.00	8,110,436	-178,873	7,931,563	167,087.77	47.47	27.00
28.00	Administrative & General under contract (see inst.)		1,620,217	0	1,620,217	14,562.00	111.26	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,268,785	0	1,268,785	32,276.00	39.31	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	742,430	0	742,430	44,670.00	16.62	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	627,583	-144,520	483,063	25,992.24	18.58	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	144,520	144,520	7,737.74	18.68	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,141,576	0	1,141,576	29,406.75	38.82	38.00
39.00	Central Services and Supply	14.00	188,935	0	188,935	9,361.72	20.18	39.00
40.00	Pharmacy	15.00	784,394	0	784,394	18,622.83	42.12	40.00
41.00	Medical Records & Medical Records Library	16.00	248,488	0	248,488	10,149.33	24.48	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 07/01/2020
To 06/30/2021Worksheet S-3
Part III
Date/Time Prepared:
11/24/2021 9:09 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)	34,182,709	-178,873	34,003,836	918,104.69	37.04	1.00
2.00	Excluded area salaries (see instructions)	1,965,941	0	1,965,941	61,316.58	32.06	2.00
3.00	Subtotal salaries (line 1 minus line 2)	32,216,768	-178,873	32,037,895	856,788.11	37.39	3.00
4.00	Subtotal other wages & related costs (see inst.)	280,923	0	280,923	2,080.00	135.06	4.00
5.00	Subtotal wage-related costs (see inst.)	5,573,091	0	5,573,091	0.00	17.40	5.00
6.00	Total (sum of lines 3 thru 5)	38,070,782	-178,873	37,891,909	858,868.11	44.12	6.00
7.00	Total overhead cost (see instructions)	15,173,731	-178,873	14,994,858	370,994.38	40.42	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part IV
Date/Time Prepared:
11/24/2021 9:09 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)	213,539	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	67,647	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)	2,714,175	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)	53,083	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	324,854	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	2,572,990	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	8,378	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	114,655	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	6,069,321	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 07/01/2020
To 06/30/2021Worksheet S-3
Part V
Date/Time Prepared:
11/24/2021 9:09 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	6,069,321	1.00
2.00	Hospital	0	6,069,321	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 07/01/2020
To 06/30/2021

Worksheet S-10

Date/Time Prepared:
11/24/2021 9:09 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)		0.773520	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		4,936,923	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		1,193,250	5.00
6.00	Medicaid charges		28,297,760	6.00
7.00	Medicaid cost (line 1 times line 6)		21,888,883	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)		15,758,710	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)		15,758,710	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)	5,507,805	80,604	5,588,409
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	4,260,397	80,604	4,341,001
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)	4,260,397	80,604	4,341,001
			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)		3,301,736	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		316,211	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		486,478	27.01
28.00	Non-Medicare bad debt expense (see instructions)		2,815,258	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		2,347,925	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		6,688,926	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		22,447,636	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021

Worksheet A

Date/Time Prepared:
11/24/2021 9:09 am

	Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,491,756	2,491,756	-265,360	2,226,396
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	265,360	265,360
3.00	00300	OTHER CAP REL COSTS		0	0	0	0
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	440,887	3,650,084	4,090,971	0	4,090,971
5.01	01160	COMMUNICATIONS	159,115	77,950	237,065	0	237,065
5.02	00591	COVID	57,442	4,460,935	4,518,377	0	4,518,377
5.04	00570	ADMITTING	370,775	39,192	409,967	0	409,967
5.05	00580	BUSINESS OFFICE	489,542	5,021,831	5,511,373	0	5,511,373
5.06	00590	OTHER ADMINISTRATIVE	7,033,562	19,259,365	26,292,927	-201,130	26,091,797
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00	00700	OPERATION OF PLANT	1,268,785	1,846,087	3,114,872	0	3,114,872
8.00	00800	LAUNDRY & LINEN SERVICE	0	230,176	230,176	0	230,176
9.00	00900	HOUSEKEEPING	742,430	261,215	1,003,645	0	1,003,645
10.00	01000	DIETARY	627,583	959,766	1,587,349	-365,535	1,221,814
11.00	01100	CAFETERIA	0	0	0	365,535	365,535
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	1,141,576	201,249	1,342,825	0	1,342,825
14.00	01400	CENTRAL SERVICES & SUPPLY	188,935	608,861	797,796	-31,735	766,061
15.00	01500	PHARMACY	784,394	1,261,750	2,046,144	-649,732	1,396,412
16.00	01600	MEDICAL RECORDS & LIBRARY	248,488	682,790	931,278	0	931,278
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	54,104	27,277	81,381	193,630	275,011
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	350,134	350,134	60,000	410,134
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,243,946	2,481,443	10,725,389	-30,000	10,695,389
31.00	03100	INTENSIVE CARE UNIT	1,488,455	293,456	1,781,911	0	1,781,911
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	321,415	868,713	1,190,128	-144,090	1,046,038
53.00	05300	ANESTHESIOLOGY	0	119,329	119,329	-119,329	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,380,016	2,198,826	3,578,842	-29,830	3,549,012
57.00	05700	CT SCAN	94,013	11,178	105,191	0	105,191
60.00	06000	LABORATORY	855,125	3,334,207	4,189,332	0	4,189,332
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	603,801	342,533	946,334	-45,030	901,304
66.00	06600	PHYSICAL THERAPY	373,897	79,702	453,599	-609	452,990
69.00	06900	ELECTROCARDIOLOGY	63,868	56,973	120,841	0	120,841
70.00	07000	ELECTROENCEPHALOGRAPHY	16,958	3,830	20,788	0	20,788
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	381,798	381,798
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	65,863	13,704	79,567	646,519	726,086
74.00	07400	RENAL DIALYSIS	0	81,292	81,292	0	81,292
75.01	07501	HYBERBARIC CHAMBER	0	0	0	0	0
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	0
76.10	03950	PARTIAL HOSPITALIZATION	238,202	21,620	259,822	0	259,822
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	12,128	5,143	17,271	-3,895	13,376
90.01	09001	CICERO CLINIC	0	7,200	7,200	0	7,200
90.02	09002	YMCA CLINIC	0	-191	-191	0	-191
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	3,285,350	1,184,819	4,470,169	0	4,470,169
91.01	09101	GOLDEN LIFE	0	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
	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)		30,650,655	52,534,195	83,184,850	26,567	83,211,417
	NONREIMBURSABLE COST CENTERS						
194.00	07950	PUBLIC RELATIONS	42,972	141,481	184,453	0	184,453
194.01	07952	RESEARCH	69,755	79,152	148,907	0	148,907

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021

Worksheet A

Date/Time Prepared:
11/24/2021 9:09 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	
194.02	07953	OPMH	835,990	103,615	939,605	0	939,605	194.02
194.03	07954	CLINIC OTHER	1,017,224	2,061,281	3,078,505	-26,567	3,051,938	194.03
194.10	07951	AUSTIN PRIDE	0	0	0	0	0	194.10
200.00		TOTAL (SUM OF LINES 118 through 199)	32,616,596	54,919,724	87,536,320	0	87,536,320	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021

Worksheet A

Date/Time Prepared:
11/24/2021 9:09 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-23,662	2,202,734	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	265,360	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,090,971	4.00
5.01	01160	COMMUNICATIONS	0	237,065	5.01
5.02	00591	COVID	0	4,518,377	5.02
5.04	00570	ADMITTING	0	409,967	5.04
5.05	00580	BUSINESS OFFICE	0	5,511,373	5.05
5.06	00590	OTHER ADMINISTRATIVE	-5,286,167	20,805,630	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	3,114,872	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	230,176	8.00
9.00	00900	HOUSEKEEPING	0	1,003,645	9.00
10.00	01000	DIETARY	0	1,221,814	10.00
11.00	01100	CAFETERIA	-22,556	342,979	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,342,825	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	766,061	14.00
15.00	01500	PHARMACY	0	1,396,412	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	931,278	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	275,011	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	410,134	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,524,167	9,171,222	30.00
31.00	03100	INTENSIVE CARE UNIT	-73,500	1,708,411	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	35.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-481,461	564,577	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-404,611	3,144,401	54.00
57.00	05700	CT SCAN	0	105,191	57.00
60.00	06000	LABORATORY	0	4,189,332	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	901,304	65.00
66.00	06600	PHYSICAL THERAPY	0	452,990	66.00
69.00	06900	ELECTROCARDIOLOGY	0	120,841	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	20,788	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	381,798	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	726,086	73.00
74.00	07400	RENAL DIALYSIS	0	81,292	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	259,822	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	13,376	90.00
90.01	09001	CICERO CLINIC	0	7,200	90.01
90.02	09002	YMCA CLINIC	0	-191	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	-159,072	4,311,097	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)	-7,975,196	75,236,221	118.00
NONREIMBURSABLE COST CENTERS					
194.00	07950	PUBLIC RELATIONS	0	184,453	194.00
194.01	07952	RESEARCH	0	148,907	194.01
194.02	07953	OPMH	0	939,605	194.02
194.03	07954	CLINIC OTHER	0	3,051,938	194.03

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021

Worksheet A

Date/Time Prepared:
11/24/2021 9:09 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
194.10	07951	AUSTIN PRIDE	0	0	194.10
200.00		TOTAL (SUM OF LINES 118 through 199)	-7,975,196	79,561,124	200.00

	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	646,519	
	TOTALS		0	646,519	
1.00	B - CAFETERIA RECLASS				1.00
	CAFETERIA	11.00	144,520	221,015	
	TOTALS		144,520	221,015	
1.00	D - DEPR EXP				1.00
	CAP REL COSTS-MVBLE EQUIP	2.00	0	265,360	
	TOTALS		0	265,360	
1.00 2.00 3.00 5.00 6.00 7.00 8.00 10.00 11.00	E - MEDICAL SUPPLIES CHARGED TO PATIENTS				1.00 2.00 3.00 5.00 6.00 7.00 8.00 10.00 11.00
	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	381,798	
		0.00	0	0	
		0.00	0	0	
		0.00	0	0	
		0.00	0	0	
		0.00	0	0	
		0.00	0	0	
		0.00	0	0	
		0.00	0	0	
	TOTALS		0	381,798	
	1.00 2.00 3.00	G - DIRECTOR PSYCH RESIDENCY			
I&R SERVICES-OTHER PRGM COSTS APPRV		22.00	0	60,000	
		0.00	0	0	
		0.00	0	0	
TOTALS			0	60,000	
1.00	H - PSYCH RESIDENTS				1.00
	I&R SERVICES-SALARY & FRINGES APPRV	21.00	178,873	14,757	
	TOTALS		178,873	14,757	
500.00	Grand Total: Increases				500.00

	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	646,519	0		
	TOTALS		0	646,519			
1.00	B - CAFETERIA RECLASS						1.00
	DIETARY	10.00	144,520	221,015	0		
	TOTALS		144,520	221,015			
1.00	D - DEPR EXP						1.00
	CAP REL COSTS-BLDG & FIXT	1.00	0	265,360	9		
	TOTALS		0	265,360			
1.00 2.00 3.00 5.00 6.00 7.00 8.00 10.00 11.00	E - MEDICAL SUPPLIES CHARGED TO PATIENTS						1.00 2.00 3.00 5.00 6.00 7.00 8.00 10.00 11.00
	OPERATING ROOM	50.00	0	144,090	0		
	ANESTHESIOLOGY	53.00	0	119,329	0		
	RESPIRATORY THERAPY	65.00	0	45,030	0		
	PHYSICAL THERAPY	66.00	0	609	0		
	CENTRAL SERVICES & SUPPLY	14.00	0	31,735	0		
	PHARMACY	15.00	0	3,213	0		
	CLINIC	90.00	0	3,895	0		
	RADIOLOGY-DIAGNOSTIC	54.00	0	29,830	0		
	CLINIC OTHER	194.03	0	4,067	0		
	TOTALS		0	381,798			
1.00 2.00 3.00	G - DIRECTOR PSYCH RESIDENCY						1.00 2.00 3.00
	OTHER ADMINISTRATIVE	5.06	0	7,500	0		
	ADULTS & PEDIATRICS	30.00	0	30,000	0		
	CLINIC OTHER	194.03	0	22,500	0		
	TOTALS		0	60,000			
1.00	H - PSYCH RESIDENTS						1.00
	OTHER ADMINISTRATIVE	5.06	178,873	14,757	0		
	TOTALS		178,873	14,757			
500.00	Grand Total: Decreases			323,393	1,589,449		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part I
Date/Time Prepared:
11/24/2021 9:09 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	41,544,524	1,218,244	0	1,218,244	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	11,488,257	171,498	0	171,498	0	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)	53,513,952	1,389,742	0	1,389,742	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	53,513,952	1,389,742	0	1,389,742	0	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	42,762,768	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	11,659,755	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)	54,903,694	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	54,903,694	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part II
Date/Time Prepared:
11/24/2021 9:09 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	2,400,000	0	91,756	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)	2,400,000	0	91,756	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	2,491,756				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	2,491,756				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part III
Date/Time Prepared:
11/24/2021 9:09 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	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	43,243,938	0	43,243,938	0.787633	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	11,659,756	0	11,659,756	0.212367	0	2.00
3.00	Total (sum of lines 1-2)	54,903,694	0	54,903,694	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	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,110,978	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	265,360	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,376,338	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)	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	91,756	0	0	0	2,202,734	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	265,360	2.00
3.00	Total (sum of lines 1-2)	91,756	0	0	0	2,468,094	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8

Date/Time Prepared:
11/24/2021 9:09 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #	Wkst. A-7 Ref.	
				Cost Center				
		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	-3,645,278				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	-22,556	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			0CAFETERIA		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		0RESPIRATORY THERAPY		65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL 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			0CAP REL COSTS-BLDG & FIXT		1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP		2.00	0	27.00
28.00	Non-physician Anesthetist			0NONPHYSICIAN 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)			0ADULTS & 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	2,185	OTHER ADMINISTRATIVE		5.06	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8

Date/Time Prepared:
11/24/2021 9:09 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	-1,461	OPERATING ROOM	50.00	0	35.00
37.00	LOBBYING EXPENSES	A	-8,118	OTHER ADMINISTRATIVE	5.06	0	37.00
38.00	RENTAL INCOME	B	-21,380	CAP REL COSTS-BLDG & FIXT	1.00	9	38.00
39.00	MEDICAID TAX ASSESSMENT	A	-4,276,306	OTHER ADMINISTRATIVE	5.06	0	39.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7,975,196				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 07/01/2020
To 06/30/2021

Worksheet A-8-2

Date/Time Prepared:
11/24/2021 9:09 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	1,215,428	934,505	280,923	211,500	2,080	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	1,524,167	1,524,167	0	0	0	2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	73,500	73,500	0	0	0	3.00
4.00	50.00	AGGREGATE-OPERATING ROOM	480,000	480,000	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	404,611	404,611	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	91.00	AGGREGATE-EMERGENCY	159,072	159,072	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			3,856,778	3,575,855	280,923		2,080	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	211,500	10,575	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	0.00		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			211,500	10,575	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	211,500	69,423	1,003,928		1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	1,524,167		2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	73,500		3.00
4.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	480,000		4.00
5.00	0.00		0	0	0	0		5.00
6.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	404,611		6.00
7.00	0.00		0	0	0	0		7.00
8.00	91.00	AGGREGATE-EMERGENCY	0	0	0	159,072		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	211,500	69,423	3,645,278		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021Worksheet B
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	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	2,202,734	2,202,734			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	265,360		265,360		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,090,971	13,728	1,654	4,106,353	4.00
5.01	01160	COMMUNICATIONS	237,065	13,316	1,604	20,307	272,292 5.01
5.02	00591	COVID	4,518,377	0	0	7,331	0 5.02
5.04	00570	ADMITTING	409,967	1,721	207	47,319	2,778 5.04
5.05	00580	BUSINESS OFFICE	5,511,373	36,745	4,427	62,477	4,168 5.05
5.06	00590	OTHER ADMINISTRATIVE	20,805,630	481,946	58,060	874,816	81,968 5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0 6.00
7.00	00700	OPERATION OF PLANT	3,114,872	230,818	27,806	161,926	4,168 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	230,176	28,341	3,414	0	1,389 8.00
9.00	00900	HOUSEKEEPING	1,003,645	27,468	3,309	94,751	1,389 9.00
10.00	01000	DIETARY	1,221,814	72,879	8,780	61,650	6,946 10.00
11.00	01100	CAFETERIA	342,979	31,458	3,790	18,444	4,168 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	1,342,825	8,292	999	145,691	13,892 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	766,061	133,189	16,045	24,112	4,168 14.00
15.00	01500	PHARMACY	1,396,412	15,112	1,821	100,107	2,778 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	931,278	19,576	2,358	31,713	9,725 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	275,011	4,788	577	29,733	0 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	410,134	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	9,171,222	341,427	41,131	1,052,110	20,839 30.00
31.00	03100	INTENSIVE CARE UNIT	1,708,411	79,475	9,574	189,961	6,946 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	564,577	112,317	13,531	41,020	26,396 50.00
53.00	05300	ANESTHESIOLOGY	0	4,539	547	0	1,389 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,144,401	102,305	12,324	176,122	11,114 54.00
57.00	05700	CT SCAN	105,191	6,982	841	11,998	0 57.00
60.00	06000	LABORATORY	4,189,332	82,592	9,950	109,134	8,335 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	901,304	25,710	3,097	77,059	2,778 65.00
66.00	06600	PHYSICAL THERAPY	452,990	39,463	4,754	47,718	9,725 66.00
69.00	06900	ELECTROCARDIOLOGY	120,841	7,182	865	8,151	4,168 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	20,788	4,875	587	2,164	1,389 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	381,798	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	726,086	0	0	8,406	0 73.00
74.00	07400	RENAL DIALYSIS	81,292	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	259,822	85,696	10,324	30,400	2,778 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	13,376	2,207	266	1,548	1,389 90.00
90.01	09001	CICERO CLINIC	7,200	0	0	0	0 90.01
90.02	09002	YMCA CLINIC	-191	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	4,311,097	111,095	13,383	419,286	23,617 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)	75,236,221	2,125,242	256,025	3,855,454	258,400 118.00

COST ALLOCATION - GENERAL SERVICE COSTS

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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	184,453	0	0	5,484	1,389	194.00
194.01	07952	RESEARCH	148,907	3,491	421	8,902	0	194.01
194.02	07953	OPMH	939,605	44,712	5,386	106,692	9,725	194.02
194.03	07954	CLINIC OTHER	3,051,938	29,289	3,528	129,821	0	194.03
194.10	07951	AUSTIN PRIDE	0	0	0	0	2,778	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)	79,561,124	2,202,734	265,360	4,106,353	272,292	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0083

Period:
From 07/01/2020
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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	4,525,708	4,525,708				5.02
5.04	00570	ADMITTING	461,992	28,219	490,211			5.04
5.05	00580	BUSINESS OFFICE	5,619,190	343,231	0	5,962,421		5.05
5.06	00590	OTHER ADMINISTRATIVE	22,302,420	1,362,296	0	0	23,664,716	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	3,539,590	216,205	0	0	3,755,795	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	263,320	16,084	0	0	279,404	8.00
9.00	00900	HOUSEKEEPING	1,130,562	69,057	0	0	1,199,619	9.00
10.00	01000	DIETARY	1,372,069	83,809	0	0	1,455,878	10.00
11.00	01100	CAFETERIA	400,839	24,484	0	0	425,323	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,511,699	92,338	0	0	1,604,037	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	943,575	0	0	0	943,575	14.00
15.00	01500	PHARMACY	1,516,230	92,614	0	0	1,608,844	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	994,650	60,755	0	0	1,055,405	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	310,109	18,942	0	0	329,051	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	410,134	25,052	0	0	435,186	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	10,626,729	649,102	213,231	2,245,624	13,734,686	30.00
31.00	03100	INTENSIVE CARE UNIT	1,994,367	121,820	41,352	336,527	2,494,066	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	757,841	46,290	9,019	155,431	968,581	50.00
53.00	05300	ANESTHESIOLOGY	6,475	396	1,292	25,884	34,047	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,446,266	210,505	9,855	183,570	3,850,196	54.00
57.00	05700	CT SCAN	125,012	7,636	7,555	160,597	300,800	57.00
60.00	06000	LABORATORY	4,399,343	268,721	54,910	732,255	5,455,229	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,009,948	61,690	27,388	240,728	1,339,754	65.00
66.00	06600	PHYSICAL THERAPY	554,650	33,879	3,885	55,365	647,779	66.00
69.00	06900	ELECTROCARDIOLOGY	141,207	8,625	8,384	94,426	252,642	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	29,803	1,820	332	2,967	34,922	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	381,798	23,321	4,068	61,338	470,525	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	734,492	44,864	66,858	617,319	1,463,533	73.00
74.00	07400	RENAL DIALYSIS	81,292	4,965	900	7,322	94,479	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	389,020	23,762	0	89,974	502,756	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	18,786	1,147	5	19,792	39,730	90.00
90.01	09001	CICERO CLINIC	7,200	440	0	0	7,640	90.01
90.02	09002	YMCA CLINIC	-191	0	0	0	-191	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	4,878,478	297,987	41,177	933,302	6,150,944	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)	74,884,603	4,240,056	490,211	5,962,421	74,598,951	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	PUBLIC RELATIONS	191,326	11,687	0	0	203,013	194.00
194.01	07952	RESEARCH	161,721	9,878	0	0	171,599	194.01
194.02	07953	OPMH	1,106,120	67,564	0	0	1,173,684	194.02
194.03	07954	CLINIC OTHER	3,214,576	196,353	0	0	3,410,929	194.03
194.10	07951	AUSTIN PRIDE	2,778	170	0	0	2,948	194.10

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		Subtotal	COVID	ADMITTING	BUSINESS OFFICE	Subtotal	
		5A.01	5.02	5.04	5.05	5A.05	
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)	79,561,124	4,525,708	490,211	5,962,421	79,561,124	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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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	23,664,716					5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	1,617,377	0	5,373,172			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	120,321	0	106,905	506,630		8.00
9.00	00900	HOUSEKEEPING	516,598	0	103,612	0	1,819,829	9.00
10.00	01000	DIETARY	626,952	0	274,905	0	77,840	10.00
11.00	01100	CAFETERIA	183,159	0	118,663	0	25,765	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	690,754	0	31,277	0	86,646	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	502,400	0	24,461	14.00
15.00	01500	PHARMACY	692,825	0	57,003	0	46,476	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	454,494	0	73,841	0	52,618	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	141,701	0	18,060	0	15,220	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	187,406	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	5,914,656	0	1,287,887	330,717	633,968	30.00
31.00	03100	INTENSIVE CARE UNIT	1,074,032	0	299,785	24,103	83,493	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	417,105	0	423,668	151,810	27,233	50.00
53.00	05300	ANESTHESIOLOGY	14,662	0	17,120	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,658,029	0	385,901	0	92,897	54.00
57.00	05700	CT SCAN	129,535	0	26,338	0	6,034	57.00
60.00	06000	LABORATORY	2,349,213	0	311,543	0	79,579	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	576,945	0	96,981	0	48,269	65.00
66.00	06600	PHYSICAL THERAPY	278,956	0	148,858	0	28,103	66.00
69.00	06900	ELECTROCARDIOLOGY	108,796	0	27,091	0	9,404	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	15,039	0	18,390	0	1,413	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	202,625	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	630,249	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	40,686	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	216,504	0	323,254	0	50,824	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	17,109	0	8,325	0	5,762	90.00
90.01	09001	CICERO CLINIC	3,290	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	2,648,812	0	419,059	0	230,964	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)	21,527,830	0	5,080,866	506,630	1,626,969	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	PUBLIC RELATIONS	87,425	0	0	0	3,805	194.00
194.01	07952	RESEARCH	73,897	0	13,169	0	10,817	194.01
194.02	07953	OPMH	505,429	0	168,658	0	82,895	194.02
194.03	07954	CLINIC OTHER	1,468,865	0	110,479	0	95,343	194.03
194.10	07951	AUSTIN PRIDE	1,270	0	0	0	0	194.10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0083

Period:
From 07/01/2020
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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	
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)	23,664,716	0	5,373,172	506,630	1,819,829	202.00

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	
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	2,435,575					10.00
11.00	01100	CAFETERIA	0	752,910				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	35,412	0	2,448,126		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,270	0	0	1,481,706	14.00
15.00	01500	PHARMACY	0	22,414	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,221	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	0	12,922	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	2,285,912	321,057	0	1,694,243	203,816	30.00
31.00	03100	INTENSIVE CARE UNIT	149,663	31,880	0	168,287	71,095	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	4,433	0	23,426	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	42,900	0	0	20,142	54.00
57.00	05700	CT SCAN	0	2,705	0	0	3,399	57.00
60.00	06000	LABORATORY	0	29,902	0	0	380,423	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	18,708	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	14,150	0	0	612	66.00
69.00	06900	ELECTROCARDIOLOGY	0	4,984	0	0	187	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	927	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	495,918	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	88	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	6,161	0	0	245	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	526	0	0	71	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	106,535	0	562,170	302,839	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)	2,435,575	679,107	0	2,448,126	1,478,835	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	PUBLIC RELATIONS	0	1,728	0	0	0	194.00
194.01	07952	RESEARCH	0	1,227	0	0	160	194.01
194.02	07953	OPMH	0	33,358	0	0	86	194.02
194.03	07954	CLINIC OTHER	0	37,490	0	0	2,625	194.03

COST ALLOCATION - GENERAL SERVICE COSTS

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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	
194.10	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)	2,435,575	752,910	0	2,448,126	1,481,706	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	2,427,562					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,648,579				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	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	11,216	620,901	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,409	93,048	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	6,325	42,976	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	7,157	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	663	50,756	0	0	0	54.00
57.00	05700	CT SCAN	0	44,405	0	0	0	57.00
60.00	06000	LABORATORY	0	202,466	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	66,560	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	21	15,308	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	26,108	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	820	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	16,960	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,265,755	170,686	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	2,025	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	24,877	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	5,472	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	89,244	258,054	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)	2,374,633	1,648,579	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	0	0	0	0	0	194.02
194.03	07954	CLINIC OTHER	52,929	0	0	0	0	194.03

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	
194.10	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)	2,427,562	1,648,579	0	0	0	202.00

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	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	516,954					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		622,592				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	516,954	622,592	0	28,178,605	-1,139,546	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	4,490,861	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	2,065,557	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	72,986	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	6,101,484	0	54.00
57.00	05700	CT SCAN	0	0	0	513,216	0	57.00
60.00	06000	LABORATORY	0	0	0	8,808,355	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	2,147,217	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,133,787	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	429,212	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	71,511	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,186,028	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,530,311	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	137,190	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	1,124,621	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	76,995	0	90.00
90.01	09001	CICERO CLINIC	0	0	0	10,930	0	90.01
90.02	09002	YMCA CLINIC	0	0	0	-191	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	10,768,621	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)	516,954	622,592	0	71,847,296	-1,139,546	118.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0083

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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	295,971	0	194.00
194.01	07952	RESEARCH	0	0	0	270,869	0	194.01
194.02	07953	OPMH	0	0	0	1,964,110	0	194.02
194.03	07954	CLINIC OTHER	0	0	0	5,178,660	0	194.03
194.10	07951	AUSTIN PRIDE	0	0	0	4,218	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)	516,954	622,592	0	79,561,124	-1,139,546	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0083

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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	IMPL. DEV. 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
200.00		Cross Foot Adjustments	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		Total	
		26.00	
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118 through 201)	78,421,578	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0083

Period:
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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						1.00
2.00	00200						2.00
4.00	00400	0	13,728	1,654	15,382	15,382	4.00
5.01	01160	0	13,316	1,604	14,920	76	5.01
5.02	00591	0	0	0	0	27	5.02
5.04	00570	0	1,721	207	1,928	177	5.04
5.05	00580	0	36,745	4,427	41,172	234	5.05
5.06	00590	425	481,946	58,060	540,431	3,277	5.06
6.00	00600	0	0	0	0	0	6.00
7.00	00700	0	230,818	27,806	258,624	606	7.00
8.00	00800	0	28,341	3,414	31,755	0	8.00
9.00	00900	0	27,468	3,309	30,777	355	9.00
10.00	01000	0	72,879	8,780	81,659	231	10.00
11.00	01100	0	31,458	3,790	35,248	69	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	0	8,292	999	9,291	546	13.00
14.00	01400	154	133,189	16,045	149,388	90	14.00
15.00	01500	70,151	15,112	1,821	87,084	375	15.00
16.00	01600	43	19,576	2,358	21,977	119	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	4,788	577	5,365	111	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	341,427	41,131	382,558	3,942	30.00
31.00	03100	0	79,475	9,574	89,049	711	31.00
35.00	02040	0	0	0	0	0	35.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	112,317	13,531	125,848	154	50.00
53.00	05300	0	4,539	547	5,086	0	53.00
54.00	05400	172	102,305	12,324	114,801	660	54.00
57.00	05700	0	6,982	841	7,823	45	57.00
60.00	06000	0	82,592	9,950	92,542	409	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	21,918	25,710	3,097	50,725	289	65.00
66.00	06600	0	39,463	4,754	44,217	179	66.00
69.00	06900	0	7,182	865	8,047	31	69.00
70.00	07000	0	4,875	587	5,462	8	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	31	73.00
74.00	07400	0	0	0	0	0	74.00
75.01	07501	0	0	0	0	0	75.01
76.00	03550	0	0	0	0	0	76.00
76.10	03950	0	85,696	10,324	96,020	114	76.10
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	7,200	2,207	266	9,673	6	90.00
90.01	09001	0	0	0	0	0	90.01
90.02	09002	0	0	0	0	0	90.02
90.03	09003	0	0	0	0	0	90.03
90.04	09004	0	0	0	0	0	90.04
90.05	09005	0	0	0	0	0	90.05
91.00	09100	0	111,095	13,383	124,478	1,570	91.00
91.01	09101	0	0	0	0	0	91.01
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20
99.30	09930	0	0	0	0	0	99.30
99.40	09940	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00							
	SUBTOTALS (SUM OF LINES 1 through 117)	100,063	2,125,242	256,025	2,481,330	14,442	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	0	0	0	0	21	194.00

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			
			1.00	2.00			
		0			2A	4.00	
194.01	07952	RESEARCH	0	3,491	421	3,912	33
194.02	07953	OPMH	38,500	44,712	5,386	88,598	400
194.03	07954	CLINIC OTHER	123,217	29,289	3,528	156,034	486
194.10	07951	AUSTIN PRIDE	0	0	0	0	0
200.00		Cross Foot Adjustments			0	0	0
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	261,780	2,202,734	265,360	2,729,874	15,382

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0083

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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	14,996					5.01
5.02	00591	COVID	0	27				5.02
5.04	00570	ADMITTING	153	0	2,258			5.04
5.05	00580	BUSINESS OFFICE	230	0	0	41,636		5.05
5.06	00590	OTHER ADMINISTRATIVE	4,506	27	0	0	548,241	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	230	0	0	0	37,472	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	77	0	0	0	2,788	8.00
9.00	00900	HOUSEKEEPING	77	0	0	0	11,969	9.00
10.00	01000	DIETARY	383	0	0	0	14,525	10.00
11.00	01100	CAFETERIA	230	0	0	0	4,243	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	765	0	0	0	16,003	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	230	0	0	0	0	14.00
15.00	01500	PHARMACY	153	0	0	0	16,051	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	536	0	0	0	10,530	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	0	0	0	3,283	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	4,342	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	1,148	0	979	15,709	137,006	30.00
31.00	03100	INTENSIVE CARE UNIT	383	0	191	2,347	24,883	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	1,454	0	42	1,084	9,664	50.00
53.00	05300	ANESTHESIOLOGY	77	0	6	181	340	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	612	0	45	1,281	38,413	54.00
57.00	05700	CT SCAN	0	0	35	1,120	3,001	57.00
60.00	06000	LABORATORY	459	0	253	5,108	54,427	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	153	0	126	1,679	13,367	65.00
66.00	06600	PHYSICAL THERAPY	536	0	18	386	6,463	66.00
69.00	06900	ELECTROCARDIOLOGY	230	0	39	659	2,521	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	77	0	2	21	348	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	19	428	4,694	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	309	4,306	14,602	73.00
74.00	07400	RENAL DIALYSIS	0	0	4	51	943	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	153	0	0	628	5,016	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	77	0	0	138	396	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	76	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	1,301	0	190	6,510	61,368	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)	14,230	27	2,258	41,636	498,734	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	PUBLIC RELATIONS	77	0	0	0	2,025	194.00
194.01	07952	RESEARCH	0	0	0	0	1,712	194.01
194.02	07953	OPMH	536	0	0	0	11,710	194.02
194.03	07954	CLINIC OTHER	0	0	0	0	34,031	194.03
194.10	07951	AUSTIN PRIDE	153	0	0	0	29	194.10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0083

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Cost Center Description		COMMUNICATIONS	COVID	ADMITTING	BUSINESS OFFICE	OTHER ADMINISTRATIVE	
		5.01	5.02	5.04	5.05	5.06	
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)	14,996	27	2,258	41,636	548,241	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0083

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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	296,932				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	5,908	40,528			8.00
9.00	00900	HOUSEKEEPING	0	5,726	0	48,904		9.00
10.00	01000	DIETARY	0	15,192	0	2,092	114,082	10.00
11.00	01100	CAFETERIA	0	6,558	0	692	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,728	0	2,328	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	27,764	0	657	0	14.00
15.00	01500	PHARMACY	0	3,150	0	1,249	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,081	0	1,414	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	998	0	409	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	71,171	26,456	17,036	107,072	30.00
31.00	03100	INTENSIVE CARE UNIT	0	16,567	1,928	2,244	7,010	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	23,413	12,144	732	0	50.00
53.00	05300	ANESTHESIOLOGY	0	946	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	21,326	0	2,496	0	54.00
57.00	05700	CT SCAN	0	1,455	0	162	0	57.00
60.00	06000	LABORATORY	0	17,216	0	2,139	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	5,359	0	1,297	0	65.00
66.00	06600	PHYSICAL THERAPY	0	8,226	0	755	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,497	0	253	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,016	0	38	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
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	17,864	0	1,366	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	460	0	155	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	23,158	0	6,207	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)		0	280,779	40,528	43,721	114,082	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	PUBLIC RELATIONS	0	0	0	102	0	194.00
194.01	07952	RESEARCH	0	728	0	291	0	194.01
194.02	07953	OPMH	0	9,320	0	2,228	0	194.02
194.03	07954	CLINIC OTHER	0	6,105	0	2,562	0	194.03
194.10	07951	AUSTIN PRIDE	0	0	0	0	0	194.10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021Worksheet B
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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	
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	296,932	40,528	48,904	114,082	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
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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	47,040					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	2,212	0	32,873			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	704	0	0	178,833		14.00
15.00	01500	PHARMACY	1,400	0	0	0	109,462	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	764	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	807	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	20,060	0	22,749	24,599	506	30.00
31.00	03100	INTENSIVE CARE UNIT	1,992	0	2,260	8,581	64	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	277	0	315	0	285	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,680	0	0	2,431	30	54.00
57.00	05700	CT SCAN	169	0	0	410	0	57.00
60.00	06000	LABORATORY	1,868	0	0	45,915	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,169	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	884	0	0	74	1	66.00
69.00	06900	ELECTROCARDIOLOGY	311	0	0	23	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	58	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	59,853	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	11	102,165	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	385	0	0	30	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	33	0	0	9	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	6,656	0	7,549	36,551	4,024	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)	42,429	0	32,873	178,487	107,075	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	PUBLIC RELATIONS	108	0	0	0	0	194.00
194.01	07952	RESEARCH	77	0	0	19	0	194.01
194.02	07953	OPMH	2,084	0	0	10	0	194.02
194.03	07954	CLINIC OTHER	2,342	0	0	317	2,387	194.03

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0083

Period:
From 07/01/2020
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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	
194.10	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)	47,040	0	32,873	178,833	109,462	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0083

Period:
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To 06/30/2021Worksheet B
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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	39,421				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		10,973	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	14,860	0			30.00
31.00	03100	INTENSIVE CARE UNIT	2,224	0			31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0			35.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,027	0			50.00
53.00	05300	ANESTHESIOLOGY	171	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,213	0			54.00
57.00	05700	CT SCAN	1,061	0			57.00
60.00	06000	LABORATORY	4,839	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0			62.30
65.00	06500	RESPIRATORY THERAPY	1,591	0			65.00
66.00	06600	PHYSICAL THERAPY	366	0			66.00
69.00	06900	ELECTROCARDIOLOGY	624	0			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	20	0			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	405	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,079	0			73.00
74.00	07400	RENAL DIALYSIS	48	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	595	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	131	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	6,167	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)	39,421	0	0	0	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	PUBLIC RELATIONS	0	0			194.00
194.01	07952	RESEARCH	0	0			194.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0083

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To 06/30/2021Worksheet B
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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	
194.02	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	10,973	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	39,421	0	0	0	10,973	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021Worksheet 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	4,342				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		845,851	0	845,851	30.00
31.00	03100	INTENSIVE CARE UNIT		160,434	0	160,434	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT		0	0	0	35.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		176,439	0	176,439	50.00
53.00	05300	ANESTHESIOLOGY		6,807	0	6,807	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		185,988	0	185,988	54.00
57.00	05700	CT SCAN		15,281	0	15,281	57.00
60.00	06000	LABORATORY		225,175	0	225,175	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY		75,755	0	75,755	65.00
66.00	06600	PHYSICAL THERAPY		62,105	0	62,105	66.00
69.00	06900	ELECTROCARDIOLOGY		14,235	0	14,235	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		7,050	0	7,050	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		65,399	0	65,399	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		125,503	0	125,503	73.00
74.00	07400	RENAL DIALYSIS		1,046	0	1,046	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		122,171	0	122,171	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		11,078	0	11,078	90.00
90.01	09001	CICERO CLINIC		76	0	76	90.01
90.02	09002	YMCA CLINIC		0	0	0	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		285,729	0	285,729	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	2,386,122	0	2,386,122

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
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11/24/2021 9:09 am

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			SERVICES-OTHER PRGM COSTS APPRV					
			22.00					
	NONREIMBURSABLE COST CENTERS							
194.00	07950	PUBLIC RELATIONS			2,333	0	2,333	194.00
194.01	07952	RESEARCH			6,772	0	6,772	194.01
194.02	07953	OPMH			114,886	0	114,886	194.02
194.03	07954	CLINIC OTHER			204,264	0	204,264	194.03
194.10	07951	AUSTIN PRIDE			182	0	182	194.10
200.00		Cross Foot Adjustments	4,342	0	15,315	0	15,315	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,342	0	2,729,874	0	2,729,874	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/24/2021 9:09 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	5.01	5A.02	
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	32,175,709			4.00
5.01	01160	COMMUNICATIONS	1,068	1,068	159,115	196		5.01
5.02	00591	COVID	0	0	57,442	0	-4,525,708	5.02
5.04	00570	ADMITTING	138	138	370,775	2	0	5.04
5.05	00580	BUSINESS OFFICE	2,947	2,947	489,542	3	0	5.05
5.06	00590	OTHER ADMINISTRATIVE	38,653	38,653	6,854,689	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	1,268,785	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	742,430	1	0	9.00
10.00	01000	DIETARY	5,845	5,845	483,063	5	0	10.00
11.00	01100	CAFETERIA	2,523	2,523	144,520	3	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	665	665	1,141,576	10	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,682	10,682	188,935	3	-943,575	14.00
15.00	01500	PHARMACY	1,212	1,212	784,394	2	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,570	1,570	248,488	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	232,977	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	8,243,946	15	0	30.00
31.00	03100	INTENSIVE CARE UNIT	6,374	6,374	1,488,455	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	321,415	19	0	50.00
53.00	05300	ANESTHESIOLOGY	364	364	0	1	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,205	8,205	1,380,016	8	0	54.00
57.00	05700	CT SCAN	560	560	94,013	0	0	57.00
60.00	06000	LABORATORY	6,624	6,624	855,125	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	603,801	2	0	65.00
66.00	06600	PHYSICAL THERAPY	3,165	3,165	373,897	7	0	66.00
69.00	06900	ELECTROCARDIOLOGY	576	576	63,868	3	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	391	391	16,958	1	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	65,863	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	6,873	6,873	238,202	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	12,128	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	191	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	3,285,350	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	30,209,768	186	-5,469,092	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/24/2021 9:09 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				
	NONREIMBURSABLE COST CENTERS							
194.00	07950	PUBLIC RELATIONS	0	0	42,972	1	0	194.00
194.01	07952	RESEARCH	280	280	69,755	0	0	194.01
194.02	07953	OPMH	3,586	3,586	835,990	7	0	194.02
194.03	07954	CLINIC OTHER	2,349	2,349	1,017,224	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)	2,202,734	265,360	4,106,353	272,292		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.468564	1.502069	0.127623	1,389.244898		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			15,382	14,996		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000478	76.510204		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 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/24/2021 9:09 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	74,092,032				5.02
5.04	00570	ADMITTING	461,992	61,160,240			5.04
5.05	00580	BUSINESS OFFICE	5,619,190	0	91,410,663		5.05
5.06	00590	OTHER ADMINISTRATIVE	22,302,420	0	0	-23,664,716	54,953,024
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	3,539,590	0	0	0	3,755,795
8.00	00800	LAUNDRY & LINEN SERVICE	263,320	0	0	0	279,404
9.00	00900	HOUSEKEEPING	1,130,562	0	0	0	1,199,619
10.00	01000	DIETARY	1,372,069	0	0	0	1,455,878
11.00	01100	CAFETERIA	400,839	0	0	0	425,323
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	1,511,699	0	0	0	1,604,037
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	-943,575	0
15.00	01500	PHARMACY	1,516,230	0	0	0	1,608,844
16.00	01600	MEDICAL RECORDS & LIBRARY	994,650	0	0	0	1,055,405
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	310,109	0	0	0	329,051
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	410,134	0	0	0	435,186
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	10,626,729	26,602,385	34,428,145	0	13,734,686
31.00	03100	INTENSIVE CARE UNIT	1,994,367	5,159,325	5,159,325	0	2,494,066
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	757,841	1,125,258	2,382,927	0	968,581
53.00	05300	ANESTHESIOLOGY	6,475	161,190	396,834	0	34,047
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,446,266	1,229,608	2,814,332	0	3,850,196
57.00	05700	CT SCAN	125,012	942,569	2,462,132	0	300,800
60.00	06000	LABORATORY	4,399,343	6,850,884	11,226,260	0	5,455,229
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	1,009,948	3,417,135	3,690,614	0	1,339,754
66.00	06600	PHYSICAL THERAPY	554,650	484,759	848,800	0	647,779
69.00	06900	ELECTROCARDIOLOGY	141,207	1,046,073	1,447,650	0	252,642
70.00	07000	ELECTROENCEPHALOGRAPHY	29,803	41,446	45,485	0	34,922
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	381,798	507,526	940,382	0	470,525
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	734,492	8,341,644	9,464,166	0	1,463,533
74.00	07400	RENAL DIALYSIS	81,292	112,255	112,255	0	94,479
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	389,020	0	1,379,400	0	502,756
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	18,786	658	303,434	0	39,730
90.01	09001	CICERO CLINIC	7,200	0	0	0	7,640
90.02	09002	YMCA CLINIC	0	0	0	191	0
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	4,878,478	5,137,525	14,308,522	0	6,150,944
91.01	09101	GOLDEN LIFE	0	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
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)	69,415,511	61,160,240	91,410,663	-24,608,100	49,990,851
NONREIMBURSABLE COST CENTERS							
194.00	07950	PUBLIC RELATIONS	191,326	0	0	0	203,013
194.01	07952	RESEARCH	161,721	0	0	0	171,599
194.02	07953	OPMH	1,106,120	0	0	0	1,173,684

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/24/2021 9:09 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	
194.03	07954 CLINIC OTHER	3,214,576	0	0	0	3,410,929	194.03
194.10	07951 AUSTIN PRIDE	2,778	0	0	0	2,948	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)	4,525,708	490,211	5,962,421		23,664,716	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.061082	0.008015	0.065227		0.430635	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	27	2,258	41,636		548,241	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000037	0.000455		0.009977	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 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/24/2021 9:09 am

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	60,099 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	56,406 30.00
31.00	03100	INTENSIVE CARE UNIT	0	6,374	12,273	1,536	3,693 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	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0 74.00
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	60,099 118.00
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
194.02	07953	OPMH	0	3,586	0	1,525	0 194.02

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/24/2021 9:09 am

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	
194.03	07954	0	2,349	0	1,754	0	194.03
194.10	07951	0	0	0	0	0	194.10
200.00							200.00
201.00							201.00
202.00							202.00
203.00							203.00
204.00							204.00
205.00							205.00
206.00							206.00
207.00							207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/24/2021 9:09 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	
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	30,064					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	1,414	0	385,315			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	450	0	0	1,140,738		14.00
15.00	01500	PHARMACY	895	0	0	0	692,414	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	488	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	516	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	12,820	0	266,660	156,914	3,199	30.00
31.00	03100	INTENSIVE CARE UNIT	1,273	0	26,487	54,735	402	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	177	0	3,687	0	1,804	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,713	0	0	15,507	189	54.00
57.00	05700	CT SCAN	108	0	0	2,617	0	57.00
60.00	06000	LABORATORY	1,194	0	0	292,881	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	747	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	565	0	0	471	6	66.00
69.00	06900	ELECTROCARDIOLOGY	199	0	0	144	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	37	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	381,797	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	68	646,262	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	246	0	0	189	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	21	0	0	55	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	4,254	0	88,481	233,150	25,455	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)	27,117	0	385,315	1,138,528	677,317	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	PUBLIC RELATIONS	69	0	0	0	0	194.00
194.01	07952	RESEARCH	49	0	0	123	0	194.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/24/2021 9:09 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	
194.02	07953	OPMH	1,332	0	0	66	0	194.02
194.03	07954	CLINIC OTHER	1,497	0	0	2,021	15,097	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)	752,910	0	2,448,126	1,481,706	2,427,562	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	25.043574	0.000000	6.353570	1.298901	3.505940	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	47,040	0	32,873	178,833	109,462	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.564662	0.000000	0.085315	0.156770	0.158088	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 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/24/2021 9:09 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	91,410,663					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	34,428,145	0	0	0	100	30.00
31.00	03100	INTENSIVE CARE UNIT	5,159,325	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	2,382,927	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	396,834	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,814,332	0	0	0	0	54.00
57.00	05700	CT SCAN	2,462,132	0	0	0	0	57.00
60.00	06000	LABORATORY	11,226,260	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	3,690,614	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	848,800	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	1,447,650	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	45,485	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	940,382	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,464,166	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	112,255	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	1,379,400	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	303,434	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	14,308,522	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)	91,410,663	0	0	0	100	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/24/2021 9:09 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)	1,648,579	0	0	516,954	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.018035	0.000000	0.000000	5,169.540000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	39,421	0	0	10,973	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000431	0.000000	0.000000	109.730000	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 07/01/2020
To 06/30/2021Worksheet B-1
Date/Time Prepared:
11/24/2021 9:09 am

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	100	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	100	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	35.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
57.00	05700	CT SCAN	0	57.00
60.00	06000	LABORATORY	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
74.00	07400	RENAL DIALYSIS	0	74.00
75.01	07501	HYBERBARIC CHAMBER	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699	LITHOTRIPSY	0	76.99
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	90.00
90.01	09001	CICERO CLINIC	0	90.01
90.02	09002	YMCA CLINIC	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0	90.03
90.04	09004	CLINIC #4	0	90.04
90.05	09005	WOUND CARE	0	90.05
91.00	09100	EMERGENCY	0	91.00
91.01	09101	GOLDEN LIFE	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	99.40
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021Worksheet B-1
Date/Time Prepared:
11/24/2021 9:09 am

Cost Center Description		INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)		
		SERVICES-OTHER			
		PRGM COSTS APPRV (ASSIGNED T IME))			
		22.00			23.00
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)	622,592	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6,225.920000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	4,342	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	43.420000	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

Worksheet C
Part I
Date/Time Prepared:
11/24/2021 9:09 am

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COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/24/2021 9:09 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	9.00	10.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	26,602,385		26,602,385			30.00	
31.00	03100	INTENSIVE CARE UNIT	5,159,325		5,159,325			31.00	
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0		0			35.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,125,258	1,257,669	2,382,927	0.866815	0.000000	50.00	
53.00	05300	ANESTHESIOLOGY	161,190	235,644	396,834	0.183921	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,229,608	1,584,724	2,814,332	2.168004	0.000000	54.00	
57.00	05700	CT SCAN	942,569	1,519,563	2,462,132	0.208444	0.000000	57.00	
60.00	06000	LABORATORY	6,850,884	4,375,376	11,226,260	0.784621	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	3,417,135	273,479	3,690,614	0.581805	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	484,759	364,041	848,800	1.335753	0.000000	66.00	
69.00	06900	ELECTROCARDIOLOGY	1,046,073	401,577	1,447,650	0.296489	0.000000	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	41,446	4,039	45,485	1.572189	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	507,526	432,856	940,382	1.261219	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	8,341,644	1,122,522	9,464,166	0.478680	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	112,255	0	112,255	1.222128	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	1,379,400	1,379,400	0.815297	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	658	302,776	303,434	0.253745	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	5,137,525	9,170,997	14,308,522	0.752602	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	7,825,760	7,825,760	0.341476	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)	61,160,240	30,250,423	91,410,663			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	61,160,240	30,250,423	91,410,663			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
35.00	02040 DETOXIFICATION INTENSIVE CARE UNIT				35.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.866815			50.00
53.00	05300 ANESTHESIOLOGY	0.183921			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2.168004			54.00
57.00	05700 CT SCAN	0.208444			57.00
60.00	06000 LABORATORY	0.784621			60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500 RESPIRATORY THERAPY	0.581805			65.00
66.00	06600 PHYSICAL THERAPY	1.335753			66.00
69.00	06900 ELECTROCARDIOLOGY	0.296489			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1.572189			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.261219			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.478680			73.00
74.00	07400 RENAL DIALYSIS	1.222128			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	0.815297			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	0.253745			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	0.752602			91.00
91.01	09101 GOLDEN LIFE	0.000000			91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.341476			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:
From 07/01/2020
To 06/30/2021Worksheet C
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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	28,178,605		28,178,605	0
31.00	03100	INTENSIVE CARE UNIT	4,490,861		4,490,861	0
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0		0	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,065,557		2,065,557	0
53.00	05300	ANESTHESIOLOGY	72,986		72,986	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,101,484		6,101,484	0
57.00	05700	CT SCAN	513,216		513,216	0
60.00	06000	LABORATORY	8,808,355		8,808,355	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0
65.00	06500	RESPIRATORY THERAPY	2,147,217	0	2,147,217	0
66.00	06600	PHYSICAL THERAPY	1,133,787	0	1,133,787	0
69.00	06900	ELECTROCARDIOLOGY	429,212		429,212	0
70.00	07000	ELECTROENCEPHALOGRAPHY	71,511		71,511	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,186,028		1,186,028	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	4,530,311		4,530,311	0
74.00	07400	RENAL DIALYSIS	137,190		137,190	0
75.01	07501	HYPERBARIC CHAMBER	0		0	0
76.00	03550	O/P MENTAL HEALTH	0		0	0
76.10	03950	PARTIAL HOSPITALIZATION	1,124,621		1,124,621	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	76,995		76,995	0
90.01	09001	CICERO CLINIC	10,930		10,930	0
90.02	09002	YMCA CLINIC	0		0	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	10,768,621		10,768,621	0
91.01	09101	GOLDEN LIFE	0		0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,784,929		2,784,929	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)	74,632,416	0	74,632,416	0
201.00		Less Observation Beds	2,784,929		2,784,929	0
202.00		Total (see instructions)	71,847,487	0	71,847,487	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021Worksheet C
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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	IMPL. DEV. 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:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
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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	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
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 07/01/2020
To 06/30/2021Worksheet D
Part I
Date/Time Prepared:
11/24/2021 9:09 am

			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	845,851	0	845,851	21,137	40.02	30.00
31.00	INTENSIVE CARE UNIT	160,434		160,434	985	162.88	31.00
35.00	DETOXIFICATION INTENSIVE CARE UNIT	0		0	0	0.00	35.00
200.00	Total (lines 30 through 199)	1,006,285		1,006,285	22,122		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	3,360	134,467				30.00
31.00	INTENSIVE CARE UNIT	446	72,644				31.00
35.00	DETOXIFICATION INTENSIVE CARE UNIT	0	0				35.00
200.00	Total (lines 30 through 199)	3,806	207,111				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part II
Date/Time Prepared:
11/24/2021 9:09 am

				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	176,439	2,382,927	0.074043	446,731	33,077	50.00
53.00	05300	ANESTHESIOLOGY	6,807	396,834	0.017153	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	185,988	2,814,332	0.066086	299,991	19,825	54.00
57.00	05700	CT SCAN	15,281	2,462,132	0.006206	185,247	1,150	57.00
60.00	06000	LABORATORY	225,175	11,226,260	0.020058	1,213,941	24,349	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	75,755	3,690,614	0.020526	767,885	15,762	65.00
66.00	06600	PHYSICAL THERAPY	62,105	848,800	0.073168	161,610	11,825	66.00
69.00	06900	ELECTROCARDIOLOGY	14,235	1,447,650	0.009833	254,134	2,499	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,050	45,485	0.154996	14,290	2,215	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	65,399	940,382	0.069545	126,990	8,832	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	125,503	9,464,166	0.013261	1,781,442	23,624	73.00
74.00	07400	RENAL DIALYSIS	1,046	112,255	0.009318	42,185	393	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	122,171	1,379,400	0.088568	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	11,078	303,434	0.036509	658	24	90.00
90.01	09001	CICERO CLINIC	76	0	0.000000	0	0	90.01
90.02	09002	YMCA CLINIC	0	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	285,729	14,308,522	0.019969	661,180	13,203	91.00
91.01	09101	GOLDEN LIFE	0	0	0.000000	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	83,598	7,825,760	0.010682	0	0	92.00
200.00		Total (lines 50 through 199)	1,463,435	59,648,953		5,956,284	156,778	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part III
Date/Time Prepared:
11/24/2021 9:09 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	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	21,137	0.00	3,360	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	985	0.00	446	31.00	
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT		0	0	0.00	0	35.00	
200.00		Total (lines 30 through 199)		0	22,122		3,806	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 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/24/2021 9:09 am	
				Title XVIII		Hospital		PPS	
Cost Center Description				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	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
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 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/24/2021 9:09 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	2,382,927	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	396,834	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,814,332	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	2,462,132	0.000000	57.00
60.00	06000	LABORATORY	0	0	0	11,226,260	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	3,690,614	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	848,800	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,447,650	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	45,485	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	940,382	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,464,166	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	112,255	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	1,379,400	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	303,434	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	14,308,522	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	7,825,760	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	59,648,953		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0083		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/24/2021 9:09 am	
				Title XVIII		Hospital		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000		446,731	0	204,007	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000		0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		299,991	0	147,140	0	54.00
57.00	05700	CT SCAN	0.000000		185,247	0	134,809	0	57.00
60.00	06000	LABORATORY	0.000000		1,213,941	0	172,648	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		767,885	0	18,588	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000		161,610	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		254,134	0	75,617	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		14,290	0	1,154	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		126,990	0	33,198	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		1,781,442	0	131,733	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000		42,185	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		658	0	2,909	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		661,180	0	523,518	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	148,640	0	92.00
200.00		Total (lines 50 through 199)			5,956,284	0	1,593,961	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/24/2021 9:09 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	0.866815	204,007	0	0	176,836	50.00
53.00	05300	ANESTHESIOLOGY	0.183921	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2.168004	147,140	0	0	319,000	54.00
57.00	05700	CT SCAN	0.208444	134,809	0	0	28,100	57.00
60.00	06000	LABORATORY	0.784621	172,648	1,710	0	135,463	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.581805	18,588	0	0	10,815	65.00
66.00	06600	PHYSICAL THERAPY	1.335753	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.296489	75,617	0	0	22,420	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.572189	1,154	0	0	1,814	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.261219	33,198	0	0	41,870	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.478680	131,733	0	1,042	63,058	73.00
74.00	07400	RENAL DIALYSIS	1.222128	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	0.815297	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	0.253745	2,909	0	0	738	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	0.752602	523,518	0	0	394,001	91.00
91.01	09101	GOLDEN LIFE	0.000000	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.341476	148,640	0	0	50,757	92.00
200.00		Subtotal (see instructions)		1,593,961	1,710	1,042	1,244,872	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		1,593,961	1,710	1,042	1,244,872	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/24/2021 9:09 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	1,342	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	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	499		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)	1,342	499		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	1,342	499		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part I
Date/Time Prepared:
11/24/2021 9:09 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	845,851	0	845,851	21,137	40.02	30.00
31.00	INTENSIVE CARE UNIT	160,434		160,434	985	162.88	31.00
35.00	DETOXIFICATION INTENSIVE CARE UNIT	0		0	0	0.00	35.00
200.00	Total (lines 30 through 199)	1,006,285		1,006,285	22,122		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	1,559	62,391				30.00
31.00	INTENSIVE CARE UNIT	44	7,167				31.00
35.00	DETOXIFICATION INTENSIVE CARE UNIT	0	0				35.00
200.00	Total (lines 30 through 199)	1,603	69,558				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part II
Date/Time Prepared:
11/24/2021 9:09 am

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	176,439	0	0.000000	0	0	50.00
53.00	05300 ANESTHESIOLOGY	6,807	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	185,988	0	0.000000	0	0	54.00
57.00	05700 CT SCAN	15,281	0	0.000000	0	0	57.00
60.00	06000 LABORATORY	225,175	0	0.000000	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	75,755	0	0.000000	0	0	65.00
66.00	06600 PHYSICAL THERAPY	62,105	0	0.000000	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	14,235	0	0.000000	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	7,050	0	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	65,399	0	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	125,503	0	0.000000	0	0	73.00
74.00	07400 RENAL DIALYSIS	1,046	0	0.000000	0	0	74.00
75.01	07501 HYPERBARIC 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	122,171	0	0.000000	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	11,078	0	0.000000	0	0	90.00
90.01	09001 CICERO CLINIC	76	0	0.000000	0	0	90.01
90.02	09002 YMCA CLINIC	0	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	285,729	0	0.000000	0	0	91.00
91.01	09101 GOLDEN LIFE	0	0	0.000000	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	83,595	0	0.000000	0	0	92.00
200.00	Total (lines 50 through 199)	1,463,432	0		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part III
Date/Time Prepared:
11/24/2021 9:09 am

				Title XIX		Hospital	Cost		
Cost Center Description			Nursing School	Nursing School	Allied Health	Allied Health	All Other		
			Post-Stepdown		Post-Stepdown	Cost	Medical		
			Adjustments		Adjustments		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	Total Costs	Total Patient	Per Diem (col.	Inpatient		
			Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days		
			Amount (see	1 through 3,					
			instructions)	minus col. 4)					
			4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	21,137	0.00	1,559	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	985	0.00	44	31.00	
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT		0	0	0.00	0	35.00	
200.00		Total (lines 30 through 199)		0	22,122		1,603	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 07/01/2020
To 06/30/2021

Worksheet D
Part IV
Date/Time Prepared:
11/24/2021 9:09 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	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
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 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/24/2021 9:09 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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0.000000
57.00	05700	CT SCAN	0	0	0	0	0.000000
60.00	06000	LABORATORY	0	0	0	0	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000
75.01	07501	HYPERBARIC CHAMBER	0	0	0	0	0.000000
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	0.000000
76.10	03950	PARTIAL HOSPITALIZATION	0	0	0	0	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0.000000
90.01	09001	CICERO CLINIC	0	0	0	0	0.000000
90.02	09002	YMCA CLINIC	0	0	0	0	0.000000
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	0.000000
90.04	09004	CLINIC #4	0	0	0	0	0.000000
90.05	09005	WOUND CARE	0	0	0	0	0.000000
91.00	09100	EMERGENCY	0	0	0	0	0.000000
91.01	09101	GOLDEN LIFE	0	0	0	0	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000
200.00		Total (lines 50 through 199)	0	0	0	0	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/24/2021 9:09 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	IMPL. DEV. 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 07/01/2020
To 06/30/2021

Worksheet D-1

Date/Time Prepared:

11/24/2021 9:09 am

Title XVIII		Hospital	PPS
Cost Center Description			
PART I - ALL PROVIDER COMPONENTS		1.00	
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	21,137	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	21,137	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)	19,048	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)	3,360	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)	27,039,059	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)	27,039,059	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)	27,039,059	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)	1,279.23	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,298,213	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)	4,298,213	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021

Worksheet D-1

Date/Time Prepared:
11/24/2021 9:09 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	4,490,861	985	4,559.25	446	2,033,426	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0.00	0	0	47.00
	Cost Center Description						
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					4,351,388	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					10,683,027	49.00
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					207,111	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					156,778	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					363,889	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					10,319,138	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					2,089	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,279.23	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,672,311	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021

Worksheet D-1

Date/Time Prepared:
11/24/2021 9:09 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	845,851	27,039,059	0.031283	2,672,311	83,598	90.00
91.00 Nursing School cost	0	27,039,059	0.000000	2,672,311	0	91.00
92.00 Allied health cost	0	27,039,059	0.000000	2,672,311	0	92.00
93.00 All other Medical Education	0	27,039,059	0.000000	2,672,311	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021

Worksheet D-1

Date/Time Prepared:
11/24/2021 9:09 am

Title XIX		Hospital	Cost
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)	21,137	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	21,137	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)	19,048	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)	1,559	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)	28,178,605	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	28,178,605	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	28,178,605	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY			
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,333.14	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,078,365	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)	2,078,365	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021

Worksheet D-1

Date/Time Prepared:
11/24/2021 9:09 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	4,490,861	985	4,559.25	44	200,607	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0.00	0	0	47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,278,972	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					2,089	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,333.14	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,784,929	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021

Worksheet D-1

Date/Time Prepared:
11/24/2021 9:09 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	845,851	28,178,605	0.030017	2,784,929	83,595	90.00
91.00	Nursing School cost	0	28,178,605	0.000000	2,784,929	0	91.00
92.00	Allied health cost	0	28,178,605	0.000000	2,784,929	0	92.00
93.00	All other Medical Education	0	28,178,605	0.000000	2,784,929	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0083	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/24/2021 9:09 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		4,675,329	30.00
31.00	03100	INTENSIVE CARE UNIT		1,125,100	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT		0	35.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.866815	446,731	50.00
53.00	05300	ANESTHESIOLOGY	0.183921	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2.168004	299,991	54.00
57.00	05700	CT SCAN	0.208444	185,247	57.00
60.00	06000	LABORATORY	0.784621	1,213,941	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.581805	767,885	65.00
66.00	06600	PHYSICAL THERAPY	1.335753	161,610	66.00
69.00	06900	ELECTROCARDIOLOGY	0.296489	254,134	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.572189	14,290	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.261219	126,990	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.478680	1,781,442	73.00
74.00	07400	RENAL DIALYSIS	1.222128	42,185	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	0.815297	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	0.253745	658	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	0.752602	661,180	91.00
91.01	09101	GOLDEN LIFE	0.000000	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.341476	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,956,284	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)		5,956,284	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A
Date/Time Prepared:
11/24/2021 9:09 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)			1,157,730	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			3,131,325	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)			45,122	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			452,747	2.04
3.00	Managed Care Simulated Payments			2,721,201	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			116.28	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.			0.92	11.00
12.00	Current year allowable FTE (see instructions)			0.92	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.			1.53	15.00
16.00	Adjustment for residents in initial years of the program			3.33	16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00	17.00
18.00	Adjusted rolling average FTE count			4.86	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.041796	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.016178	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.016178	21.00
22.00	IME payment adjustment (see instructions)			37,757	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			23,955	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)			37,757	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			23,955	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			24.33	30.00
31.00	Percentage of Medicaid patient days (see instructions)			64.58	31.00
32.00	Sum of lines 30 and 31			88.91	32.00
33.00	Allowable disproportionate share percentage (see instructions)			62.57	33.00
34.00	Disproportionate share adjustment (see instructions)			670,916	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0083	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/24/2021 9:09 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)	1,264,298	1,113,302		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	317,802	832,689		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,150,491			36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 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)	6,646,088			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	0			48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)		6,670,043	49.00	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		424,093	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).		132,645	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)		7,226,781	59.00	
60.00	Primary payer payments		0	60.00	
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		7,226,781	61.00	
62.00	Deductibles billed to program beneficiaries		377,484	62.00	
63.00	Coinsurance billed to program beneficiaries		128,854	63.00	
64.00	Allowable bad debts (see instructions)		425,560	64.00	
65.00	Adjusted reimbursable bad debts (see instructions)		276,614	65.00	
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		291,558	66.00	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		6,997,057	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)			70.89	
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90	
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91	
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92	
70.93	HVBP payment adjustment amount (see instructions)		0	70.93	
70.94	HRR adjustment amount (see instructions)		-7,094	70.94	
70.95	Recovery of accelerated depreciation		0	70.95	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0083	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/24/2021 9:09 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)		18,286	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		6,971,677	71.00
71.01	Sequestration adjustment (see instructions)		0	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		6,668,509	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)		303,168	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		141,684	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	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	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 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/24/2021 9:09 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	1,157,730	1,157,730		1,157,730	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,131,325		3,131,325	3,131,325	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	45,122	45,122		45,122	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	452,747		452,747	452,747	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	2,721,201	506,235	2,214,966	2,721,201	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.016178	0.016178	0.016178		5.00
6.00	IME payment adjustment (see instructions)	22.00	37,757	10,191	27,566	37,757	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	23,955	4,456	19,499	23,955	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	37,757	10,191	27,566	37,757	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	23,955	4,456	19,499	23,955	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.6257	0.6257	0.6257		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	670,916	181,098	489,818	670,916	11.00
11.01	Uncompensated care payments	36.00	1,150,491	317,802	832,689	1,150,491	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	6,646,088	1,711,943	4,934,145	6,646,088	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,670,043	1,716,399	4,953,644	6,670,043	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	424,093	114,251	309,842	424,093	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			1,830,650	5,263,486	7,094,136	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/24/2021 9:09 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	332,683	92,158	240,525	332,683	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	17,388	1,587	15,801	17,388	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	0.0253	0.0253	0.0253		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	8,417	2,332	6,085	8,417	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1972	0.1972	0.1972		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	65,605	18,174	47,431	65,605	25.00
26.00	Total prospective capital payments (see instructions)	12.00	424,093	114,251	309,842	424,093	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	0	0	0	0	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-7,094	-2,084	-5,010	-7,094	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		18,286	0	18,286	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 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/24/2021 9:09 am
		Title XVIII	Hospital	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		1,841	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		1,244,872	2.00
3.00	OPPS payments		385,344	3.00
4.00	Outlier payment (see instructions)		30,633	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)		1,841	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		2,752	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)		2,752	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)		2,752	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		911	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)		1,841	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)		415,977	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)		88,104	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)		329,714	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		15,480	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)		345,194	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		345,194	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)		60,918	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		39,597	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		36,654	36.00
37.00	Subtotal (see instructions)		384,791	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)		384,791	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		399,572	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)		-14,781	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 07/01/2020
To 06/30/2021Worksheet E-1
Part I
Date/Time Prepared:
11/24/2021 9:09 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		6,668,509		399,572	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)		6,668,509		399,572	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		303,168		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		14,781	6.02	
7.00	Total Medicare program liability (see instructions)		6,971,677		384,791	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part II
Date/Time Prepared:
11/24/2021 9:09 am

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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0083	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part VII Date/Time Prepared: 11/24/2021 9:09 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		2,278,972		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)		2,278,972	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)		2,278,972	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)		2,278,972	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		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)		2,278,972	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		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		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 07/01/2020 To 06/30/2021	Worksheet E-4 Date/Time Prepared: 11/24/2021 9:09 am	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.00	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	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		0.92		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	0.92		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	2.07		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	2.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	1.66		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	3.33		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	4.99		17.00
18.00	Per resident amount	104,969.42	104,969.42		18.00
19.00	Approved amount for resident costs	0	523,797	523,797	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)			523,797	25.00
		Inpatient Part A	Managed Care Prior to 1/1	Managed Care On or after 1/1	Total
		1.00	2.00	2.01	3.00
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	3,806	404	1,534	26.00
27.00	Total Inpatient Days (see instructions)	20,033	20,033	20,033	27.00
28.00	Ratio of inpatient days to total inpatient days	0.189987	0.020167	0.076574	28.00
29.00	Program direct GME amount	99,515	10,563	40,109	150,187
29.01	Percent reduction for MA DGME		4.07	4.07	29.01
30.00	Reduction for direct GME payments for Medicare Advantage		430	1,632	2,062
31.00	Net Program direct GME amount			148,125	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0083	Period: From 07/01/2020 To 06/30/2021	Worksheet E-4 Date/Time Prepared: 11/24/2021 9:09 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)			112,255	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)			10,683,027	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)			10,683,027	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			1,246,713	42.00
43.00	Primary payer payments (see instructions)			0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			1,246,713	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			11,929,740	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.895495	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.104505	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			148,125	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			132,645	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			15,480	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 07/01/2020
To 06/30/2021

Worksheet G

Date/Time Prepared:
11/24/2021 9:09 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	-426,845	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	86,516,296	0	0	0	4.00
5.00 Other receivable	0	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-75,481,343	0	0	0	6.00
7.00 Inventory	1,092,785	0	0	0	7.00
8.00 Prepaid expenses	961,822	0	0	0	8.00
9.00 Other current assets	4,101,059	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)	16,763,774	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	-42,677	0	0	0	14.00
15.00 Buildings	42,431,615	0	0	0	15.00
16.00 Accumulated depreciation	-27,530,200	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	11,659,755	0	0	0	19.00
20.00 Accumulated depreciation	-10,003,533	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)	16,996,131	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	994,958	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	994,958	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	34,754,863	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	7,936,515	0	0	0	37.00
38.00 Salaries, wages, and fees payable	2,513,103	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)	10,449,618	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	13,915,138	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	13,915,138	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	24,364,756	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	10,390,107				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)	10,390,107	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	34,754,863	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021

Worksheet G-1

Date/Time Prepared:
11/24/2021 9:09 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		11,031,422		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,417,670				2.00
3.00	Total (sum of line 1 and line 2)		13,449,092		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)		13,449,092		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	3,058,985		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)		3,058,985		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		10,390,107		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 07/01/2020
To 06/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
11/24/2021 9:09 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	28,308,469		28,308,469	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)	28,308,469		28,308,469	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,523,375		5,523,375	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)	5,523,375		5,523,375	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	33,831,844		33,831,844	17.00
18.00	Ancillary services	23,834,520		23,834,520	18.00
19.00	Outpatient services	5,230,575	28,781,708	34,012,283	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	8,694,310	8,694,310	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	62,896,939	37,476,018	100,372,957	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		87,536,320		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	BAD DEBTS	450,471			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)		450,471		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)		87,986,791		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021

Worksheet G-3

Date/Time Prepared:
11/24/2021 9:09 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	100,372,957	1.00
2.00	Less contractual allowances and discounts on patients' accounts	62,308,525	2.00
3.00	Net patient revenues (line 1 minus line 2)	38,064,432	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	87,986,791	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-49,922,359	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	22,556	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	21,380	22.00
23.00	Governmental appropriations	5,864,168	23.00
24.00	OTHER INCOME	34	24.00
24.01	OTHER MISC	32,525,015	24.01
24.50	COVID-19 PHE Funding	13,906,876	24.50
25.00	Total other income (sum of lines 6-24)	52,340,029	25.00
26.00	Total (line 5 plus line 25)	2,417,670	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)	2,417,670	29.00

CALCULATION OF CAPITAL PAYMENT

Provider CCN: 14-0083

Period:
From 07/01/2020
To 06/30/2021Worksheet L
Parts I-III
Date/Time Prepared:
11/24/2021 9:09 am

Title XVIII		Hospital	PPS
			1.00
PART I - FULLY PROSPECTIVE METHOD			
CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier	332,683	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	17,388	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)	54.88	3.00
4.00	Number of interns & residents (see instructions)	4.86	4.00
5.00	Indirect medical education percentage (see instructions)	2.53	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)	8,417	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	24.33	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	64.58	8.00
9.00	Sum of lines 7 and 8	88.91	9.00
10.00	Allowable disproportionate share percentage (see instructions)	19.72	10.00
11.00	Disproportionate share adjustment (see instructions)	65,605	11.00
12.00	Total prospective capital payments (see instructions)	424,093	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