

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: 14-0133	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 11/26/2021 9:13 am
--	-----------------------	---	---

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 11/26/2021	Time: 9:13 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HOLY CROSS HOSPITAL (14-0133) 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)

EXECUTIVE VP / CFO

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	1,339,739	-16,265	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	1,339,739	-16,265	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0133		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/26/2021 9:13 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 2701 WEST 68TH STREET			PO Box:				1.00	
2.00	City: CHICAGO			State: IL		Zip Code: 60629		County: COOK	
		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			HOLY CROSS HOSPITAL	140133	16974	1	07/01/1966	N
4.00	Subprovider - IPF							P	0
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
17.20	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	
21.00	Type of Control (see instructions)						1		
							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		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	
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.								
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		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/26/2021 9:13 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.	1,559	784	0	0	10,681	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)					N	N	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	Y	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					Y	Y	
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N		
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0133		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/26/2021 9:13 am			
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code					
		1.00	2.00	3.00					
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N					60.00		
		Y/N	IME	Direct GME	IME	Direct GME			
		1.00	2.00	3.00	4.00	5.00			
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00		
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01		
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02		
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03		
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04		
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05		
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06		
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
		1.00		2.00	3.00	4.00			
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10		
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20		
						1.00			
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)									
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00		
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01		
Teaching Hospitals that Claim Residents in Nonprovider Settings									
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00		
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))					
		1.00	2.00	3.00					
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/26/2021 9:13 am

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
	1.00	2.00	3.00	4.00	5.00			
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
			1.00	2.00	3.00			
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
			1.00	2.00	5.00			
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00		
			1.00	2.00	3.00			
70.00	Inpatient Psychiatric Facility PPS							
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.		N			70.00		
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	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)				N	N	0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0133	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/26/2021 9:13 am
---	-----------------------	---	--

			1.00			
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00	
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00	
			V	XIX		
			1.00	2.00		
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	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	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	Y	98.06	
Rural Providers						
105.00	Does this hospital qualify as a CAH?		N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00	
			Physical	Occupational	Speech	Respiratory
			1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N	N	N
					1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete worksheet E, Part A, lines 200 through 218, and worksheet E-2, lines 200 through 215, as applicable.				N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0133	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/26/2021 9:13 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	2,226,876	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.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB2389	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0133		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/26/2021 9:13 am		
1.00		2.00		3.00						
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.										
141.00	Name: SINAI HEALTH SYSTEM		Contractor's Name: NGS		Contractor's Number: 06101				141.00	
142.00	Street: 1500 S FAIRFIELD AVENUE		PO Box:						142.00	
143.00	City: CHICAGO		State: IL		Zip Code: 60608				143.00	
								1.00		
144.00	Are provider based physicians' costs included in Worksheet A?								Y	144.00
								1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				Y				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N				146.00	
								1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital			N	N	N	N		155.00	
156.00	Subprovider - IPF			N	N	N	N		156.00	
157.00	Subprovider - IRF			N	N	N	N		157.00	
158.00	SUBPROVIDER								158.00	
159.00	SNF			N	N	N	N		159.00	
160.00	HOME HEALTH AGENCY			N	N	N	N		160.00	
161.00	CMHC				N	N	N		161.00	
161.20	OPT				N	N	N		161.20	
161.30	OOT				N	N	N		161.30	
161.40	OSP				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	County	State	Zip Code	CBSA	FTE/Campus	
				0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00	
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)									168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								9.99	169.00
						Beginning	Ending			
						1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)									170.00
						1.00	2.00			
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N		0	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0133	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/26/2021 9:13 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		16.00
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)	Y	10/21/2021	17.00
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		18.00
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		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part II
Date/Time Prepared:
11/26/2021 9:13 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		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.		Y		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.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		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.	RAJ	SHAH		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.	630-530-7100 X 107	RAJ.SHAH@SRGROUPLLC.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part II
Date/Time Prepared:
11/26/2021 9:13 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/26/2021 9:13 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	30.00	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	135	49,275	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)		135	49,275	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	20	7,300	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 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		155	56,575	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	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
25.20 CMHC - OPT	99.20				0	25.20
25.30 CMHC - OOT	99.30				0	25.30
25.40 CMHC - OSP	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)		155				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: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/26/2021 9:13 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)	5,515	1,846	25,365			1.00
2.00	HMO and other (see instructions)	5,483	10,681				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)	5,515	1,846	25,365			7.00
8.00	INTENSIVE CARE UNIT	1,067	497	4,444			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	0			13.00
14.00	Total (see instructions)	6,582	2,343	29,809	4.57	554.23	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	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
25.20	CMHC - OPT	0	0	0	0.00	0.00	25.20
25.30	CMHC - OOT	0	0	0	0.00	0.00	25.30
25.40	CMHC - OSP	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)				4.57	554.23	27.00
28.00	Observation Bed Days		0	0			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: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/26/2021 9:13 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	1,117	365	5,558	1.00
2.00 HMO and other (see instructions)			846	1,664		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,117	365	5,558	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	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
25.20 CMHC - OPT	0.00					25.20
25.30 CMHC - OOT	0.00					25.30
25.40 CMHC - OSP	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: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part II
Date/Time Prepared:
11/26/2021 9:13 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	44,206,490	-1,888,632	42,317,858	1,135,759.00	37.26
2.00	Non-physician anesthetist Part A		0	0	0	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	9.00
10.00	Excluded area salaries (see instructions)		0	0	0	0.00	10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,993,465	0	2,993,465	28,173.00	106.25
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	14.00
14.01	Home office salaries		7,354,746	0	7,354,746	127,558.00	57.66
14.02	Related organization salaries		0	0	0	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	16.02
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		6,863,335	0	6,863,335		17.00
18.00	Wage-related costs (other) (see instructions)						18.00
19.00	Excluded areas		0	0	0		19.00
20.00	Non-physician anesthetist Part A		0	0	0		20.00
21.00	Non-physician anesthetist Part B		0	0	0		21.00
22.00	Physician Part A - Administrative		0	0	0		22.00
22.01	Physician Part A - Teaching		0	0	0		22.01
23.00	Physician Part B		0	0	0		23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0		24.00
25.00	Interns & residents (in an approved program)		0	0	0		25.00
25.50	Home office wage-related (core)		1,095,614	0	1,095,614		25.50
25.51	Related organization wage-related (core)		0	0	0		25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		25.52

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part II
Date/Time Prepared:
11/26/2021 9:13 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	85,306	0	85,306	2,536.00	33.64	26.00
27.00	Administrative & General	5.00	2,551,416	-85,910	2,465,506	76,728.00	32.13	27.00
28.00	Administrative & General under contract (see inst.)		45,072	0	45,072	235.00	191.80	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,546,003	0	2,546,003	89,628.00	28.41	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,076,320	0	1,076,320	61,713.00	17.44	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	789,267	-337,086	452,181	44,320.00	10.20	34.00
35.00	Dietary under contract (see instructions)		121,506	0	121,506	2,752.00	44.15	35.00
36.00	Cafeteria	11.00	0	337,086	337,086	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,245,413	-55,000	1,190,413	9,364.00	127.13	38.00
39.00	Central Services and Supply	14.00	339,524	0	339,524	14,540.00	23.35	39.00
40.00	Pharmacy	15.00	2,170,254	0	2,170,254	43,819.00	49.53	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	-10,570	10,570	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: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part III
Date/Time Prepared:
11/26/2021 9:13 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)	44,373,068	-1,888,632	42,484,436	1,138,746.00	37.31	1.00
2.00	Excluded area salaries (see instructions)	0	0	0	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)	44,373,068	-1,888,632	42,484,436	1,138,746.00	37.31	3.00
4.00	Subtotal other wages & related costs (see inst.)	10,348,211	0	10,348,211	155,731.00	66.45	4.00
5.00	Subtotal wage-related costs (see inst.)	7,958,949	0	7,958,949	0.00	18.73	5.00
6.00	Total (sum of lines 3 thru 5)	62,680,228	-1,888,632	60,791,596	1,294,477.00	46.96	6.00
7.00	Total overhead cost (see instructions)	10,959,511	-130,340	10,829,171	345,635.00	31.33	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part IV
Date/Time Prepared:
11/26/2021 9:13 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	437,396	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	1,949,276	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	764,669	9.00
10.00	Dental, Hearing and Vision Plan	37,500	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	35,852	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)	438,401	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	208,698	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	2,952,729	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	36,270	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	2,544	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	6,863,335	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: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part V
Date/Time Prepared:
11/26/2021 9:13 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	2,993,465	6,863,335	1.00
2.00	Hospital	2,993,465	6,863,335	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	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
16.20	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: 14-0133

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

Worksheet S-10

Date/Time Prepared:
11/26/2021 9:13 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)		0.211686	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		30,020,612	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		226,044,714	6.00
7.00	Medicaid cost (line 1 times line 6)		47,850,501	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		17,829,889	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)		17,829,889	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	49,759,635	764,149	50,523,784
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	10,533,418	764,149	11,297,567
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)	10,533,418	764,149	11,297,567
			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)		16,601,125	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		897,191	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		1,380,293	27.01
28.00	Non-Medicare bad debt expense (see instructions)		15,220,832	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		3,705,139	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		15,002,706	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		32,832,595	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0133

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

Worksheet A

Date/Time Prepared:
11/26/2021 9:13 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		0	0	6,999,803	6,999,803	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	85,306	6,559,142	6,644,448	0	6,644,448	4.00
5.01	00540	NONPATIENT TELEPHONES	287,697	3,707	291,404	0	291,404	5.01
5.02	00550	DATA PROCESSING	0	0	0	0	0	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	62,950	-192,595	-129,645	0	-129,645	5.03
5.04	00570	ADMITTING	583,866	27,792	611,658	0	611,658	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	1,616,903	29,722,119	31,339,022	-6,999,803	24,339,219	5.06
7.00	00700	OPERATION OF PLANT	2,546,003	4,926,697	7,472,700	0	7,472,700	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	634,190	634,190	0	634,190	8.00
9.00	00900	HOUSEKEEPING	1,076,320	666,542	1,742,862	0	1,742,862	9.00
10.00	01000	DIETARY	789,267	1,020,623	1,809,890	-772,981	1,036,909	10.00
11.00	01100	CAFETERIA	0	0	0	772,981	772,981	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,245,413	111,620	1,357,033	0	1,357,033	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	339,524	15,434	354,958	0	354,958	14.00
15.00	01500	PHARMACY	2,170,254	3,105,185	5,275,439	-2,270,128	3,005,311	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	-10,570	2,124	-8,446	0	-8,446	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,374,664	2,368,003	14,742,667	-404,895	14,337,772	30.00
31.00	03100	INTENSIVE CARE UNIT	5,112,448	739,466	5,851,914	-394,158	5,457,756	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,073,474	974,619	2,048,093	-277,193	1,770,900	50.00
51.00	05100	RECOVERY ROOM	82,998	447	83,445	-353	83,092	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,652,224	748,347	2,400,571	-216,401	2,184,170	54.00
54.02	03630	ULTRA SOUND	428,618	21,304	449,922	-8,223	441,699	54.02
56.00	05600	RADIOISOTOPE	332,722	580,504	913,226	-7,632	905,594	56.00
57.00	05700	CT SCAN	621,098	120,009	741,107	-31,816	709,291	57.00
59.00	05900	CARDIAC CATHETERIZATION	8,508	156,764	165,272	-4,295	160,977	59.00
60.00	06000	LABORATORY	146,490	4,654,492	4,800,982	0	4,800,982	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,487,783	289,823	1,777,606	-67,159	1,710,447	65.00
66.00	06600	PHYSICAL THERAPY	212,537	8,435	220,972	-185	220,787	66.00
67.00	06700	OCCUPATIONAL THERAPY	243,498	2,944	246,442	-30	246,412	67.00
68.00	06800	SPEECH PATHOLOGY	95,705	1,116	96,821	0	96,821	68.00
69.00	06900	ELECTROCARDIOLOGY	374,699	114,185	488,884	-11,162	477,722	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	51,118	1,661	52,779	-636	52,143	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,015,199	2,015,199	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	50,689	50,689	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,270,128	2,270,128	73.00
74.00	07400	RENAL DIALYSIS	512,494	123,834	636,328	0	636,328	74.00
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	245,039	224,258	469,297	-11,224	458,073	90.00
91.00	09100	EMERGENCY	7,940,274	3,111,010	11,051,284	-630,507	10,420,777	91.00
91.01	04950	BEHAVIORAL HEALTH @ CASIMIR	417,166	183,390	600,556	-19	600,537	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.20	09921	OPT	0	0	0	0	0	99.20
99.30	09931	OOT	0	0	0	0	0	99.30
99.40	09941	OSP	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44,206,490	61,027,191	105,233,681	0	105,233,681	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	SISTERS & PRIESTS MAINTENANCE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	5,717	5,717	0	5,717	192.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0133

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

Worksheet A

Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
194.00	07950	SEASON HOSPICE	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	44,206,490	61,032,908	105,239,398	0	105,239,398	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0133

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

Worksheet A

Date/Time Prepared:
11/26/2021 9:13 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	0	6,999,803	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-82,924	6,561,524	4.00
5.01	00540	NONPATIENT TELEPHONES	0	291,404	5.01
5.02	00550	DATA PROCESSING	0	0	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	487,336	357,691	5.03
5.04	00570	ADMITTING	0	611,658	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	3,753,249	3,753,249	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	-11,575,768	12,763,451	5.06
7.00	00700	OPERATION OF PLANT	-37,409	7,435,291	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	634,190	8.00
9.00	00900	HOUSEKEEPING	0	1,742,862	9.00
10.00	01000	DIETARY	-30,024	1,006,885	10.00
11.00	01100	CAFETERIA	0	772,981	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,357,033	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	354,958	14.00
15.00	01500	PHARMACY	-1,106,836	1,898,475	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,259,214	1,250,768	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	297,449	297,449	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,180,690	13,157,082	30.00
31.00	03100	INTENSIVE CARE UNIT	0	5,457,756	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
43.00	04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-383,037	1,387,863	50.00
51.00	05100	RECOVERY ROOM	0	83,092	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,184,170	54.00
54.02	03630	ULTRA SOUND	0	441,699	54.02
56.00	05600	RADIOISOTOPE	0	905,594	56.00
57.00	05700	CT SCAN	0	709,291	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	160,977	59.00
60.00	06000	LABORATORY	-1,099,525	3,701,457	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,710,447	65.00
66.00	06600	PHYSICAL THERAPY	0	220,787	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	246,412	67.00
68.00	06800	SPEECH PATHOLOGY	0	96,821	68.00
69.00	06900	ELECTROCARDIOLOGY	0	477,722	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	52,143	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,015,199	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	50,689	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,270,128	73.00
74.00	07400	RENAL DIALYSIS	0	636,328	74.00
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	458,073	90.00
91.00	09100	EMERGENCY	-3,387,884	7,032,893	91.00
91.01	04950	BEHAVIORAL HEALTH @ CASIMIR	0	600,537	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0	0	94.00
99.20	09921	OPT	0	0	99.20
99.30	09931	OOT	0	0	99.30
99.40	09941	OSP	0	0	99.40
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-13,086,849	92,146,832	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	SISTERS & PRIESTS MAINTENANCE	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	5,717	192.00
194.00	07950	SEASON HOSPICE	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-13,086,849	92,152,549	200.00

RECLASSIFICATIONS

Provider CCN: 14-0133

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

Worksheet A-6

Date/Time Prepared:
11/26/2021 9:13 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	337,086	435,895	1.00	
	0		337,086	435,895		
	B - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6,350,602	1.00	
	0		0	6,350,602		
	D - INSURANCE RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	649,201	1.00	
	0		0	649,201		
	E - MED SUPPLY & INPLANTABLE DEVICE					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,015,199	1.00	
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	50,689	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
	0		0	2,065,888		
	F - CHG DRUG					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,270,128	1.00	
	0		0	2,270,128		
	G - REFERRAL BONUS					
1.00	ADULTS & PEDIATRICS	30.00	3,000	0	1.00	
2.00	INTENSIVE CARE UNIT	31.00	3,333	0	2.00	
3.00	EMERGENCY	91.00	6,500	0	3.00	
	0		12,833	0		
	H - PHYSICIAN PURCHASED SVC					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	22,960	1.00	
2.00	NURSING ADMINISTRATION	13.00	0	55,000	2.00	
3.00	ADULTS & PEDIATRICS	30.00	0	82,500	3.00	
4.00	EMERGENCY	91.00	0	1,688,625	4.00	
	TOTALS		0	1,849,085		
	I - SOCIAL SERVICE					
1.00	SOCIAL SERVICE	17.00	10,570	0	1.00	
	TOTALS		10,570	0		
	J - PRUCHASING					
1.00	PURCHASING RECEIVING AND STORES	5.03	0	62,950	1.00	
	TOTALS		0	62,950		
500.00	Grand Total: Increases		360,489	13,683,749	500.00	

RECLASSIFICATIONS

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet A-6
Date/Time Prepared:
11/26/2021 9:13 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	337,086	435,895	0		1.00
	0		337,086	435,895			
	B - DEPRECIATION						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	6,350,602	9		1.00
	0		0	6,350,602			
	D - INSURANCE RECLASS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	649,201	12		1.00
	0		0	649,201			
	E - MED SUPPLY & INPLANTABLE DEVICE						
1.00	ADULTS & PEDIATRICS	30.00	0	404,895	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	394,158			2.00
3.00	OPERATING ROOM	50.00	0	277,193	0		3.00
4.00	RECOVERY ROOM	51.00	0	353	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	216,401	0		5.00
6.00	ULTRA SOUND	54.02	0	8,223	0		6.00
7.00	RADIOISOTOPE	56.00	0	7,632	0		7.00
8.00	CT SCAN	57.00	0	31,816	0		8.00
9.00	CARDIAC CATHETERIZATION	59.00	0	4,295	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	67,159	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	185	0		11.00
12.00	OCCUPATIONAL THERAPY	67.00	0	30	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	11,162	0		13.00
14.00	ELECTROENCEPHALOGRAPHY	70.00	0	636	0		14.00
15.00	CLINIC	90.00	0	11,224	0		15.00
16.00	EMERGENCY	91.00	0	630,507	0		16.00
17.00	BEHAVIORAL HEALTH @ CASIMIR	91.01	0	19	0		17.00
	0		0	2,065,888			
	F - CHG DRUG						
1.00	PHARMACY	15.00	0	2,270,128	0		1.00
	0		0	2,270,128			
	G - REFERRAL BONUS						
1.00	ADULTS & PEDIATRICS	30.00	0	3,000	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	3,333	0		2.00
3.00	EMERGENCY	91.00	0	6,500	0		3.00
	0		0	12,833			
	H - PHYSICIAN PURCHASED SVC						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	22,960	0	0		1.00
2.00	NURSING ADMINISTRATION	13.00	55,000	0	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	82,500	0	0		3.00
4.00	EMERGENCY	91.00	1,688,625	0	0		4.00
	TOTALS		1,849,085	0			
	I - SOCIAL SERVICE						
1.00	SOCIAL SERVICE	17.00	0	10,570	0		1.00
	TOTALS		0	10,570			
	J - PRUCHASING						
1.00	PURCHASING RECEIVING AND STORES	5.03	62,950	0	0		1.00
	TOTALS		62,950	0			
500.00	Grand Total: Decreases		2,249,121	11,795,117			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part I
Date/Time Prepared:
11/26/2021 9:13 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
			1.00	2.00	3.00			4.00
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,700,000	0	0	0	0	1.00	
2.00	Land Improvements	0	109,714	0	109,714	0	2.00	
3.00	Buildings and Fixtures	101,282,380	0	0	0	185,260	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	31,926,906	3,745,014	0	3,745,014	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	134,909,286	3,854,728	0	3,854,728	185,260	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	134,909,286	3,854,728	0	3,854,728	185,260	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,700,000	0					1.00
2.00	Land Improvements	109,714	0					2.00
3.00	Buildings and Fixtures	101,097,120	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	35,671,920	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	138,578,754	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	138,578,754	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part II
Date/Time Prepared:
11/26/2021 9:13 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	0	0	0	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)	0	0	0	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	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part III
Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	101,206,833	0	101,206,833	0.739390	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	35,671,919	0	35,671,919	0.260610	0	2.00
3.00	Total (sum of lines 1-2)	136,878,752	0	136,878,752	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	6,350,602	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)	0	0	0	6,350,602	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	649,201	0	0	6,999,803	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	649,201	0	0	6,999,803	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0133

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

Worksheet A-8

Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,568,903			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	669,147			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	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		0OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)	B	-265,188	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0	0.00	0	32.00
33.00	B 340B OTHER CONTRACT	B	-1,106,836	PHARMACY	15.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0133

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

Worksheet A-8

Date/Time Prepared:
11/26/2021 9:13 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	
33.01	HCH ADMINISTRATION OTH OPR RENTAL	B	-63,992	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.01
33.02	HCH EMPLOYEE BENEFIT PHARM FRINGE RE	B	-82,924	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.02
33.03	HCH GENERAL OPS INCOME MISC INV	B	-45,732	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.03
33.04	HCH GENERAL OPS OTH OPER REV-PATI	B	-101,849	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.04
33.05	HCH GENERAL OPS OTH OPR DIET VEND	B	-781	DIETARY	10.00	0	33.05
33.06	HCH GENERAL OPS PARKING REVENUE	B	-37,409	OPERATION OF PLANT	7.00	0	33.06
33.07	HCH NUTRITIONAL SVCS OTH OPR DIET CA	B	-29,243	DIETARY	10.00	0	33.07
33.08	PROVIDER MEDICAID ASSESSEMENT	B	-7,523,525	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.08
33.09	ZERO OUT NEGATIVE EXP	A	129,645	PURCHASING RECEIVING AND STORES	5.03	0	33.09
33.10	ZERO OUT NEGATIVE EXP	A	8,446	SOCIAL SERVICE	17.00	0	33.10
33.11	OPERATING INTEREST EXP	A	-45,732	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.11
33.12	LOBBYING PORTION OF ASSN DUES	A	-21,973	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.12
33.13	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-13,086,849				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0133

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

Worksheet A-8-1

Date/Time Prepared:
11/26/2021 9:13 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	5.06	OTHER ADMINISTRATIVE AND GEN	HO COST ALLOCATION	9,052,341	12,825,306	1.00
2.00	17.00	SOCIAL SERVICE	HO COST ALLOCATION	1,250,768	0	2.00
3.00	5.05	CASHIERING/ACCOUNTS RECEIVAB	HO COST ALLOCATION	3,753,249	0	3.00
3.01	5.03	PURCHASING RECEIVING AND STO	HO COST ALLOCATION	357,691	0	3.01
3.02	30.00	ADULTS & PEDIATRICS	HO COST ALLOCATION	0	117,520	3.02
3.03	60.00	LABORATORY	HO COST ALLOCATION	0	1,099,525	3.03
3.04	0.00			0	0	3.04
3.05	0.00			0	0	3.05
3.06	0.00			0	0	3.06
3.07	0.00			0	0	3.07
3.08	0.00			0	0	3.08
3.09	21.00	I&R SERVICES-SALARY & FRINGE	ALLOCATION FROM MSH	297,449	0	3.09
3.10	0.00			0	0	3.10
3.11	0.00			0	0	3.11
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			14,711,498	14,042,351	5.00

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

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office		
	1.00	2.00	3.00	4.00	5.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:						

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

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

6.00	B		0.00	SINAI HELATH SY	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-0133

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

Worksheet A-8-1

Date/Time Prepared:
11/26/2021 9:13 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-3,772,965	0		1.00
2.00	1,250,768	0		2.00
3.00	3,753,249	0		3.00
3.01	357,691	0		3.01
3.02	-117,520	0		3.02
3.03	-1,099,525	0		3.03
3.04	0	0		3.04
3.05	0	0		3.05
3.06	0	0		3.06
3.07	0	0		3.07
3.08	0	0		3.08
3.09	297,449	0		3.09
3.10	0	0		3.10
3.11	0	0		3.11
4.00	0	0		4.00
5.00	669,147			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0133

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

Worksheet A-8-2

Date/Time Prepared:
11/26/2021 9:13 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	30.00	AGGREGATE-ADULTS & PEDIATRICS	797,982	797,982	0	0	0	1.00
2.00	50.00	AGGREGATE-OPERATING ROOM	383,037	383,037	0	0	0	2.00
3.00	91.00	AGGREGATE-EMERGENCY	3,387,884	3,387,884	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			4,568,903	4,568,903	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	2.00
3.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	797,982		1.00
2.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	383,037		2.00
3.00	91.00	AGGREGATE-EMERGENCY	0	0	0	3,387,884		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	4,568,903		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
			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	6,999,803	6,999,803			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0		0		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,561,524	57,440	0	6,618,964	4.00
5.01	00540	NONPATIENT TELEPHONES	291,404	7,088	0	45,090	343,582
5.02	00550	DATA PROCESSING	0	0	0	0	0
5.03	00560	PURCHASING RECEIVING AND STORES	357,691	27,929	0	0	0
5.04	00570	ADMITTING	611,658	0	0	91,508	20,620
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	3,753,249	58,757	0	0	0
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	12,763,451	1,210,341	0	249,814	116,758
7.00	00700	OPERATION OF PLANT	7,435,291	389,693	0	399,027	13,654
8.00	00800	LAUNDRY & LINEN SERVICE	634,190	422,629	0	0	0
9.00	00900	HOUSEKEEPING	1,742,862	0	0	168,688	0
10.00	01000	DIETARY	1,006,885	261,297	0	70,869	6,409
11.00	01100	CAFETERIA	772,981	197,956	0	52,830	0
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	1,357,033	30,564	0	186,570	557
14.00	01400	CENTRAL SERVICES & SUPPLY	354,958	158,881	0	53,213	3,065
15.00	01500	PHARMACY	1,898,475	0	0	340,137	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	61,392	0	0	22,850
17.00	01700	SOCIAL SERVICE	1,250,768	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	297,449	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	13,157,082	1,435,805	0	1,926,967	63,812
31.00	03100	INTENSIVE CARE UNIT	5,457,756	327,511	0	801,781	5,852
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,387,863	412,748	0	168,242	24,800
51.00	05100	RECOVERY ROOM	83,092	28,957	0	13,008	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,184,170	359,524	0	258,948	25,636
54.02	03630	ULTRA SOUND	441,699	13,965	0	67,176	0
56.00	05600	RADIOISOTOPE	905,594	30,301	0	52,147	0
57.00	05700	CT SCAN	709,291	26,875	0	97,343	0
59.00	05900	CARDIAC CATHETERIZATION	160,977	0	0	1,333	1,951
60.00	06000	LABORATORY	3,701,457	229,231	0	22,959	11,704
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	1,710,447	41,894	0	233,176	0
66.00	06600	PHYSICAL THERAPY	220,787	117,514	0	33,310	3,065
67.00	06700	OCCUPATIONAL THERAPY	246,412	49,535	0	38,163	0
68.00	06800	SPEECH PATHOLOGY	96,821	39,523	0	15,000	0
69.00	06900	ELECTROCARDIOLOGY	477,722	40,840	0	58,725	0
70.00	07000	ELECTROENCEPHALOGRAPHY	52,143	49,588	0	8,012	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,015,199	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	50,689	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	2,270,128	59,284	0	0	6,130
74.00	07400	RENAL DIALYSIS	636,328	0	0	80,322	0
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	458,073	0	0	38,404	0
91.00	09100	EMERGENCY	7,032,893	378,100	0	980,821	16,162
91.01	04950	BEHAVIORAL HEALTH @ CASIMIR	600,537	373,832	0	65,381	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
99.20	09921	OPT	0	0	0	0	0
99.30	09931	OOT	0	0	0	0	0
99.40	09941	OSP	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	92,146,832	6,898,994	0	6,618,964	343,025
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	47,374	0	0	557

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
190.01	19001	SISTERS & PRIESTS MAINTENANCE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	5,717	0	0	0	0	192.00
194.00	07950	SEASON HOSPICE	0	53,435	0	0	0	194.00
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)	92,152,549	6,999,803	0	6,618,964	343,582	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	Subtotal	
			5.02	5.03	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	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	0					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	385,620				5.03
5.04	00570	ADMITTING	0	1,805	725,591			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	3,812,006		5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	0	8,873	0	0	14,349,237	5.06
7.00	00700	OPERATION OF PLANT	0	16,124	0	0	8,253,789	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	803	0	0	1,057,622	8.00
9.00	00900	HOUSEKEEPING	0	753	0	0	1,912,303	9.00
10.00	01000	DIETARY	0	5,630	0	0	1,351,090	10.00
11.00	01100	CAFETERIA	0	0	0	0	1,023,767	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	96	0	0	1,574,820	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	819	0	0	570,936	14.00
15.00	01500	PHARMACY	0	4,071	0	0	2,242,683	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	84,242	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	1,250,768	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	297,449	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	75,088	118,803	624,068	17,401,625	30.00
31.00	03100	INTENSIVE CARE UNIT	0	45,306	43,202	226,940	6,908,348	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	27,180	19,221	100,966	2,141,020	50.00
51.00	05100	RECOVERY ROOM	0	32	704	3,700	129,493	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	34,299	42,816	224,914	3,130,307	54.00
54.02	03630	ULTRA SOUND	0	1,114	12,505	65,687	602,146	54.02
56.00	05600	RADIOISOTOPE	0	9,658	5,328	27,989	1,031,017	56.00
57.00	05700	CT SCAN	0	7,563	72,267	379,615	1,292,954	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	4,489	757	3,975	173,482	59.00
60.00	06000	LABORATORY	0	52,123	86,615	454,987	4,559,076	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	11,402	33,223	174,521	2,204,663	65.00
66.00	06600	PHYSICAL THERAPY	0	116	1,996	10,487	387,275	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	32	3,109	16,330	353,581	67.00
68.00	06800	SPEECH PATHOLOGY	0	9	1,160	6,092	158,605	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,438	23,911	125,605	734,241	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	111	623	3,275	113,752	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	29,688	155,953	2,200,840	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,620	8,510	60,819	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	47,835	251,278	2,634,655	73.00
74.00	07400	RENAL DIALYSIS	0	5,452	4,999	26,258	753,359	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	2,359	1,789	9,397	510,022	90.00
91.00	09100	EMERGENCY	0	62,704	170,897	898,204	9,539,781	91.00
91.01	04950	BEHAVIORAL HEALTH @ CASIMIR	0	66	2,523	13,255	1,055,594	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.20	09921	OPT	0	0	0	0	0	99.20
99.30	09931	OOT	0	0	0	0	0	99.30
99.40	09941	OSP	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	385,515	725,591	3,812,006	92,045,361	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	47,931	190.00
190.01	19001	SISTERS & PRIESTS MAINTENANCE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	105	0	0	5,822	192.00
194.00	07950	SEASON HOSPICE	0	0	0	0	53,435	194.00
200.00		Cross Foot Adjustments					0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description		DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	Subtotal	
		5.02	5.03	5.04	5.05	5A.05	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	385,620	725,591	3,812,006	92,152,549	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description			OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	14,349,237					5.06
7.00	00700	OPERATION OF PLANT	1,522,246	9,776,035				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	195,057	787,195	2,039,874			8.00
9.00	00900	HOUSEKEEPING	352,686	0	0	2,264,989		9.00
10.00	01000	DIETARY	249,182	486,696	0	122,637	2,209,605	10.00
11.00	01100	CAFETERIA	188,813	368,715	0	92,908	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	290,444	56,929	0	14,345	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	105,298	295,934	0	74,569	0	14.00
15.00	01500	PHARMACY	413,618	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,537	114,349	0	28,814	0	16.00
17.00	01700	SOCIAL SERVICE	230,679	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	54,859	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,209,354	2,674,352	1,128,151	673,877	1,880,198	30.00
31.00	03100	INTENSIVE CARE UNIT	1,274,107	610,027	113,535	153,713	329,407	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	394,868	768,791	173,975	193,718	0	50.00
51.00	05100	RECOVERY ROOM	23,882	53,936	44,639	13,591	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	577,323	669,655	49,139	168,738	0	54.00
54.02	03630	ULTRA SOUND	111,054	26,011	33,162	6,554	0	54.02
56.00	05600	RADIOISOTOPE	190,150	56,439	23,786	14,221	0	56.00
57.00	05700	CT SCAN	238,460	50,059	32,181	12,614	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	31,995	0	26,525	0	0	59.00
60.00	06000	LABORATORY	840,830	426,970	0	107,587	0	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	406,606	78,032	0	19,662	0	65.00
66.00	06600	PHYSICAL THERAPY	71,425	218,883	0	55,154	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	65,211	92,265	0	23,249	0	67.00
68.00	06800	SPEECH PATHOLOGY	29,252	73,615	0	18,549	0	68.00
69.00	06900	ELECTROCARDIOLOGY	135,416	76,069	129	19,168	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	20,979	92,363	24,410	23,273	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	405,901	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,217	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	485,909	110,423	0	27,824	0	73.00
74.00	07400	RENAL DIALYSIS	138,942	0	1,503	0	0	74.00
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	94,063	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,759,422	704,255	388,739	177,457	0	91.00
91.01	04950	BEHAVIORAL HEALTH @ CASIMIR	194,683	696,304	0	175,453	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.20	09921	OPT	0	0	0	0	0	99.20
99.30	09931	OOT	0	0	0	0	0	99.30
99.40	09941	OSP	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,329,468	9,588,267	2,039,874	2,217,675	2,209,605	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	8,840	88,240	0	22,235	0	190.00
190.01	19001	SISTERS & PRIESTS MAINTENANCE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	1,074	0	0	0	0	192.00
194.00	07950	SEASON HOSPICE	9,855	99,528	0	25,079	0	194.00
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL 5.06	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	14,349,237	9,776,035	2,039,874	2,264,989	2,209,605	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/26/2021 9:13 am

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	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
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	1,674,203					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	18,193	0	1,954,731			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	28,264	0	0	1,075,001		14.00
15.00	01500	PHARMACY	85,239	0	0	0	2,741,540	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	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
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	682,928	0	937,071	18,633	46,599	30.00
31.00	03100	INTENSIVE CARE UNIT	153,057	0	384,681	9,404	36,059	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	70,782	0	75,054	13,302	14,356	50.00
51.00	05100	RECOVERY ROOM	4,264	0	11,734	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	81,503	0	28,560	832	3,943	54.00
54.02	03630	ULTRA SOUND	14,985	0	0	12	0	54.02
56.00	05600	RADIOISOTOPE	7,635	0	0	163	401,812	56.00
57.00	05700	CT SCAN	27,452	0	0	82	1,162	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	176	23	59.00
60.00	06000	LABORATORY	0	0	0	616	3,929	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	76,589	0	0	49	8,540	65.00
66.00	06600	PHYSICAL THERAPY	12,061	0	0	1	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,614	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,467	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	22,295	0	0	141	148	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,964	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	992,593	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	24,743	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,117,093	73.00
74.00	07400	RENAL DIALYSIS	19,168	0	47,269	878	1,531	74.00
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	11,817	0	13,284	4,010	369	90.00
91.00	09100	EMERGENCY	303,758	0	457,078	9,288	105,976	91.00
91.01	04950	BEHAVIORAL HEALTH @ CASIMIR	35,168	0	0	1	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.20	09921	OPT	0	0	0	0	0	99.20
99.30	09931	OOT	0	0	0	0	0	99.30
99.40	09941	OSP	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,674,203	0	1,954,731	1,074,924	2,741,540	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	SISTERS & PRIESTS MAINTENANCE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	77	0	192.00
194.00	07950	SEASON HOSPICE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description		CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		11.00	12.00	13.00	14.00	15.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	1,674,203	0	1,954,731	1,075,001	2,741,540	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		
						SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM. COSTS	
			16.00	17.00	19.00	21.00	22.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
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	242,942					16.00
17.00	01700	SOCIAL SERVICE	0	1,481,447				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0		352,308		21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0			0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	39,742	1,111,085	0	211,384	0	30.00
31.00	03100	INTENSIVE CARE UNIT	14,452	207,403	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,430	118,516	0	0	0	50.00
51.00	05100	RECOVERY ROOM	236	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,323	0	0	0	0	54.00
54.02	03630	ULTRA SOUND	4,183	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	1,782	0	0	0	0	56.00
57.00	05700	CT SCAN	24,175	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	253	0	0	0	0	59.00
60.00	06000	LABORATORY	28,975	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	11,114	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	668	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,040	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	388	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	7,999	0	0	70,462	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	209	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,931	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	542	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,002	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,672	0	0	0	0	74.00
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	598	0	0	70,462	0	90.00
91.00	09100	EMERGENCY	57,384	44,443	0	0	0	91.00
91.01	04950	BEHAVIORAL HEALTH @ CASIMIR	844	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.20	09921	OPT	0	0	0	0	0	99.20
99.30	09931	OOT	0	0	0	0	0	99.30
99.40	09941	OSP	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	242,942	1,481,447	0	352,308	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	SISTERS & PRIESTS MAINTENANCE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0133

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

 Worksheet B
 Part I
 Date/Time Prepared:
 11/26/2021 9:13 am

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		
						SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM. COSTS	
						21.00	22.00	
194.00	07950	SEASON HOSPICE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments			0	0		0 200.00
201.00		Negative Cost Centers	0	0	0	0		0 201.00
202.00		TOTAL (sum lines 118 through 201)	242,942	1,481,447	0	352,308		0 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			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	00540	NONPATIENT TELEPHONES				5.01
5.02	00550	DATA PROCESSING				5.02
5.03	00560	PURCHASING RECEIVING AND STORES				5.03
5.04	00570	ADMITTING				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL				5.06
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
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD				22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,014,999	-211,384	29,803,615	30.00
31.00	03100	INTENSIVE CARE UNIT	10,194,193	0	10,194,193	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,970,812	0	3,970,812	50.00
51.00	05100	RECOVERY ROOM	281,775	0	281,775	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,724,323	0	4,724,323	54.00
54.02	03630	ULTRA SOUND	798,107	0	798,107	54.02
56.00	05600	RADIOISOTOPE	1,727,005	0	1,727,005	56.00
57.00	05700	CT SCAN	1,679,139	0	1,679,139	57.00
59.00	05900	CARDIAC CATHETERIZATION	232,454	0	232,454	59.00
60.00	06000	LABORATORY	5,967,983	0	5,967,983	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,805,255	0	2,805,255	65.00
66.00	06600	PHYSICAL THERAPY	745,467	0	745,467	66.00
67.00	06700	OCCUPATIONAL THERAPY	546,960	0	546,960	67.00
68.00	06800	SPEECH PATHOLOGY	284,876	0	284,876	68.00
69.00	06900	ELECTROCARDIOLOGY	1,066,068	-70,462	995,606	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	277,950	0	277,950	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,609,265	0	3,609,265	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	97,321	0	97,321	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,391,906	0	5,391,906	73.00
74.00	07400	RENAL DIALYSIS	964,322	0	964,322	74.00
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	704,625	-70,462	634,163	90.00
91.00	09100	EMERGENCY	13,547,581	0	13,547,581	91.00
91.01	04950	BEHAVIORAL HEALTH @ CASIMIR	2,158,047	0	2,158,047	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	94.00
99.20	09921	OPT	0	0	0	99.20
99.30	09931	OOT	0	0	0	99.30
99.40	09941	OSP	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	91,790,433	-352,308	91,438,125	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	167,246	0	167,246	190.00
190.01	19001	SISTERS & PRIESTS MAINTENANCE	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	6,973	0	6,973	192.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
194.00	07950	SEASON HOSPICE	187,897	0	187,897		194.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	92,152,549	-352,308	91,800,241		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	57,440	0	57,440	4.00
5.01	00540	NONPATIENT TELEPHONES	0	7,088	0	7,088	5.01
5.02	00550	DATA PROCESSING	0	0	0	0	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	27,929	0	27,929	5.03
5.04	00570	ADMITTING	0	0	0	0	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	58,757	0	58,757	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	0	1,210,341	0	1,210,341	5.06
7.00	00700	OPERATION OF PLANT	0	389,693	0	389,693	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	422,629	0	422,629	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	9.00
10.00	01000	DIETARY	0	261,297	0	261,297	10.00
11.00	01100	CAFETERIA	0	197,956	0	197,956	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	30,564	0	30,564	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	158,881	0	158,881	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	61,392	0	61,392	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	1,435,805	0	1,435,805	30.00
31.00	03100	INTENSIVE CARE UNIT	0	327,511	0	327,511	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	412,748	0	412,748	50.00
51.00	05100	RECOVERY ROOM	0	28,957	0	28,957	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	359,524	0	359,524	54.00
54.02	03630	ULTRA SOUND	0	13,965	0	13,965	54.02
56.00	05600	RADIOISOTOPE	0	30,301	0	30,301	56.00
57.00	05700	CT SCAN	0	26,875	0	26,875	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	229,231	0	229,231	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	41,894	0	41,894	65.00
66.00	06600	PHYSICAL THERAPY	0	117,514	0	117,514	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	49,535	0	49,535	67.00
68.00	06800	SPEECH PATHOLOGY	0	39,523	0	39,523	68.00
69.00	06900	ELECTROCARDIOLOGY	0	40,840	0	40,840	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	49,588	0	49,588	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	59,284	0	59,284	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	378,100	0	378,100	91.00
91.01	04950	BEHAVIORAL HEALTH @ CASIMIR	0	373,832	0	373,832	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
99.20	09921	OPT	0	0	0	0	99.20
99.30	09931	OOT	0	0	0	0	99.30
99.40	09941	OSP	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	6,898,994	0	6,898,994	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	47,374	0	47,374	190.00
190.01	19001	SISTERS & PRIESTS MAINTENANCE	0	0	0	0	190.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	SEASON HOSPICE	0	53,435	0	53,435	0	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	6,999,803	0	6,999,803	57,440	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description			NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
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	00540	NONPATIENT TELEPHONES	7,479					5.01
5.02	00550	DATA PROCESSING	0	0				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	0	27,929			5.03
5.04	00570	ADMITTING	449	0	131	1,374		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	58,757	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	2,542	0	643	0	0	5.06
7.00	00700	OPERATION OF PLANT	297	0	1,168	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	58	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	55	0	0	9.00
10.00	01000	DIETARY	140	0	408	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	12	0	7	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	67	0	59	0	0	14.00
15.00	01500	PHARMACY	0	0	295	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	497	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
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,389	0	5,438	212	9,617	30.00
31.00	03100	INTENSIVE CARE UNIT	127	0	3,281	77	3,497	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	540	0	1,968	34	1,556	50.00
51.00	05100	RECOVERY ROOM	0	0	2	1	57	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	558	0	2,484	76	3,466	54.00
54.02	03630	ULTRA SOUND	0	0	81	22	1,012	54.02
56.00	05600	RADIOISOTOPE	0	0	699	10	431	56.00
57.00	05700	CT SCAN	0	0	548	129	5,850	57.00
59.00	05900	CARDIAC CATHETERIZATION	42	0	325	1	61	59.00
60.00	06000	LABORATORY	255	0	3,775	155	7,012	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	826	59	2,690	65.00
66.00	06600	PHYSICAL THERAPY	67	0	8	4	162	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	2	6	252	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1	2	94	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	539	43	1,936	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	8	1	50	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	53	2,403	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3	131	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	133	0	0	85	3,872	73.00
74.00	07400	RENAL DIALYSIS	0	0	395	9	405	74.00
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	171	3	145	90.00
91.00	09100	EMERGENCY	352	0	4,541	384	13,854	91.00
91.01	04950	BEHAVIORAL HEALTH @ CASIMIR	0	0	5	5	204	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.20	09921	OPT	0	0	0	0	0	99.20
99.30	09931	OOT	0	0	0	0	0	99.30
99.40	09941	OSP	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,467	0	27,921	1,374	58,757	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	12	0	0	0	0	190.00
190.01	19001	SISTERS & PRIESTS MAINTENANCE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	8	0	0	192.00
194.00	07950	SEASON HOSPICE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description		NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	
		5.01	5.02	5.03	5.04	5.05	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	7,479	0	27,929	1,374	58,757	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description			OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	1,215,694					5.06
7.00	00700	OPERATION OF PLANT	128,965	523,586				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	16,525	42,161	481,373			8.00
9.00	00900	HOUSEKEEPING	29,880	0	0	31,399		9.00
10.00	01000	DIETARY	21,111	26,067	0	1,700	311,338	10.00
11.00	01100	CAFETERIA	15,996	19,748	0	1,288	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	24,607	3,049	0	199	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,921	15,850	0	1,034	0	14.00
15.00	01500	PHARMACY	35,042	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,316	6,124	0	399	0	16.00
17.00	01700	SOCIAL SERVICE	19,543	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	4,648	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	271,918	143,230	266,223	9,342	264,924	30.00
31.00	03100	INTENSIVE CARE UNIT	107,943	32,672	26,792	2,131	46,414	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	33,453	41,175	41,055	2,685	0	50.00
51.00	05100	RECOVERY ROOM	2,023	2,889	10,534	188	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	48,911	35,865	11,596	2,339	0	54.00
54.02	03630	ULTRA SOUND	9,409	1,393	7,826	91	0	54.02
56.00	05600	RADIOISOTOPE	16,110	3,023	5,613	197	0	56.00
57.00	05700	CT SCAN	20,202	2,681	7,594	175	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	2,711	0	6,259	0	0	59.00
60.00	06000	LABORATORY	71,236	22,868	0	1,491	0	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	34,448	4,179	0	273	0	65.00
66.00	06600	PHYSICAL THERAPY	6,051	11,723	0	765	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,525	4,942	0	322	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,478	3,943	0	257	0	68.00
69.00	06900	ELECTROCARDIOLOGY	11,473	4,074	31	266	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,777	4,947	5,760	323	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	34,388	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	950	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	41,166	5,914	0	386	0	73.00
74.00	07400	RENAL DIALYSIS	11,771	0	355	0	0	74.00
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	7,969	0	0	0	0	90.00
91.00	09100	EMERGENCY	149,059	37,719	91,735	2,460	0	91.00
91.01	04950	BEHAVIORAL HEALTH @ CASIMIR	16,494	37,293	0	2,432	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.20	09921	OPT	0	0	0	0	0	99.20
99.30	09931	OOT	0	0	0	0	0	99.30
99.40	09941	OSP	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,214,019	513,529	481,373	30,743	311,338	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	749	4,726	0	308	0	190.00
190.01	19001	SISTERS & PRIESTS MAINTENANCE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	91	0	0	0	0	192.00
194.00	07950	SEASON HOSPICE	835	5,331	0	348	0	194.00
200.00		Cross Foot Adjustments						200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL 5.06	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	1,215,694	523,586	481,373	31,399	311,338	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/26/2021 9:13 am

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	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
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	235,446					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	2,559	0	62,616			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,975	0	0	189,249		14.00
15.00	01500	PHARMACY	11,987	0	0	0	50,276	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	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
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	96,040	0	30,017	3,280	855	30.00
31.00	03100	INTENSIVE CARE UNIT	21,525	0	12,322	1,656	661	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,954	0	2,404	2,342	263	50.00
51.00	05100	RECOVERY ROOM	600	0	376	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,462	0	915	146	72	54.00
54.02	03630	ULTRA SOUND	2,107	0	0	2	0	54.02
56.00	05600	RADIOISOTOPE	1,074	0	0	29	7,369	56.00
57.00	05700	CT SCAN	3,861	0	0	14	21	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	31	0	59.00
60.00	06000	LABORATORY	0	0	0	108	72	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	10,771	0	0	9	157	65.00
66.00	06600	PHYSICAL THERAPY	1,696	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,633	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	628	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,135	0	0	25	3	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	417	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	174,742	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,356	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	38,825	73.00
74.00	07400	RENAL DIALYSIS	2,696	0	1,514	155	28	74.00
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	1,662	0	426	706	7	90.00
91.00	09100	EMERGENCY	42,718	0	14,642	1,635	1,943	91.00
91.01	04950	BEHAVIORAL HEALTH @ CASIMIR	4,946	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.20	09921	OPT	0	0	0	0	0	99.20
99.30	09931	OOT	0	0	0	0	0	99.30
99.40	09941	OSP	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	235,446	0	62,616	189,236	50,276	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	SISTERS & PRIESTS MAINTENANCE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	13	0	192.00
194.00	07950	SEASON HOSPICE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description		CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		11.00	12.00	13.00	14.00	15.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	235,446	0	62,616	189,249	50,276	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		
						SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM. COSTS	
			16.00	17.00	19.00	21.00	22.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
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	69,728					16.00
17.00	01700	SOCIAL SERVICE	0	19,543				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0		4,648		21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0			0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,385	14,658				30.00
31.00	03100	INTENSIVE CARE UNIT	4,140	2,736				31.00
41.00	04100	SUBPROVIDER - IRF	0	0				41.00
43.00	04300	NURSERY	0	0				43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,842	1,563				50.00
51.00	05100	RECOVERY ROOM	68	0				51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0				52.00
53.00	05300	ANESTHESIOLOGY	0	0				53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,103	0				54.00
54.02	03630	ULTRA SOUND	1,198	0				54.02
56.00	05600	RADIOISOTOPE	511	0				56.00
57.00	05700	CT SCAN	6,926	0				57.00
59.00	05900	CARDIAC CATHETERIZATION	73	0				59.00
60.00	06000	LABORATORY	8,301	0				60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0				62.30
65.00	06500	RESPIRATORY THERAPY	3,184	0				65.00
66.00	06600	PHYSICAL THERAPY	191	0				66.00
67.00	06700	OCCUPATIONAL THERAPY	298	0				67.00
68.00	06800	SPEECH PATHOLOGY	111	0				68.00
69.00	06900	ELECTROCARDIOLOGY	2,291	0				69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	60	0				70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,845	0				71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	155	0				72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,584	0				73.00
74.00	07400	RENAL DIALYSIS	479	0				74.00
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	171	0				90.00
91.00	09100	EMERGENCY	16,570	586				91.00
91.01	04950	BEHAVIORAL HEALTH @ CASIMIR	242	0				91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0				94.00
99.20	09921	OPT	0	0				99.20
99.30	09931	OOT	0	0				99.30
99.40	09941	OSP	0	0				99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	69,728	19,543	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0				190.00
190.01	19001	SISTERS & PRIESTS MAINTENANCE	0	0				190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0				192.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		
						SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM. COSTS	
						21.00	22.00	
194.00	07950	SEASON HOSPICE	0	0				194.00
200.00		Cross Foot Adjustments			0	4,648	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	69,728	19,543	0	4,648	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			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	00540	NONPATIENT TELEPHONES				5.01
5.02	00550	DATA PROCESSING				5.02
5.03	00560	PURCHASING RECEIVING AND STORES				5.03
5.04	00570	ADMITTING				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL				5.06
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
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD				22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,581,057	0	2,581,057	30.00
31.00	03100	INTENSIVE CARE UNIT	600,442	0	600,442	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	555,042	0	555,042	50.00
51.00	05100	RECOVERY ROOM	45,808	0	45,808	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	483,764	0	483,764	54.00
54.02	03630	ULTRA SOUND	37,689	0	37,689	54.02
56.00	05600	RADIOISOTOPE	65,820	0	65,820	56.00
57.00	05700	CT SCAN	75,721	0	75,721	57.00
59.00	05900	CARDIAC CATHETERIZATION	9,515	0	9,515	59.00
60.00	06000	LABORATORY	344,703	0	344,703	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	100,513	0	100,513	65.00
66.00	06600	PHYSICAL THERAPY	138,470	0	138,470	66.00
67.00	06700	OCCUPATIONAL THERAPY	62,846	0	62,846	67.00
68.00	06800	SPEECH PATHOLOGY	47,167	0	47,167	68.00
69.00	06900	ELECTROCARDIOLOGY	65,166	0	65,166	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	63,001	0	63,001	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	214,431	0	214,431	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,595	0	5,595	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	154,249	0	154,249	73.00
74.00	07400	RENAL DIALYSIS	18,504	0	18,504	74.00
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	11,593	0	11,593	90.00
91.00	09100	EMERGENCY	764,809	0	764,809	91.00
91.01	04950	BEHAVIORAL HEALTH @ CASIMIR	436,020	0	436,020	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	94.00
99.20	09921	OPT	0	0	0	99.20
99.30	09931	OOT	0	0	0	99.30
99.40	09941	OSP	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,881,925	0	6,881,925	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	53,169	0	53,169	190.00
190.01	19001	SISTERS & PRIESTS MAINTENANCE	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	112	0	112	192.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
194.00	07950	SEASON HOSPICE	59,949	0	59,949		194.00
200.00		Cross Foot Adjustments	4,648	0	4,648		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	6,999,803	0	6,999,803		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0133

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

Worksheet B-1

Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	DATA PROCESSING (MACHINE TIME)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	265,663					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,180	0	42,232,552			4.00
5.01	00540	NONPATIENT TELEPHONES	269	0	287,697	1,233		5.01
5.02	00550	DATA PROCESSING	0	0	0	0	0	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	1,060	0	0	0	0	5.03
5.04	00570	ADMITTING	0	0	583,866	74	0	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,230	0	0	0	0	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	45,936	0	1,593,943	419	0	5.06
7.00	00700	OPERATION OF PLANT	14,790	0	2,546,003	49	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	16,040	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	1,076,320	0	0	9.00
10.00	01000	DIETARY	9,917	0	452,181	23	0	10.00
11.00	01100	CAFETERIA	7,513	0	337,086	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,160	0	1,190,413	2	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,030	0	339,524	11	0	14.00
15.00	01500	PHARMACY	0	0	2,170,254	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,330	0	0	82	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
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	54,493	0	12,295,164	229	0	30.00
31.00	03100	INTENSIVE CARE UNIT	12,430	0	5,115,781	21	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	15,665	0	1,073,474	89	0	50.00
51.00	05100	RECOVERY ROOM	1,099	0	82,998	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,645	0	1,652,224	92	0	54.00
54.02	03630	ULTRA SOUND	530	0	428,618	0	0	54.02
56.00	05600	RADIOISOTOPE	1,150	0	332,722	0	0	56.00
57.00	05700	CT SCAN	1,020	0	621,098	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	8,508	7	0	59.00
60.00	06000	LABORATORY	8,700	0	146,490	42	0	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,590	0	1,487,783	0	0	65.00
66.00	06600	PHYSICAL THERAPY	4,460	0	212,537	11	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,880	0	243,498	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,500	0	95,705	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,550	0	374,699	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,882	0	51,118	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	2,250	0	0	22	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	512,494	0	0	74.00
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	245,039	0	0	90.00
91.00	09100	EMERGENCY	14,350	0	6,258,149	58	0	91.00
91.01	04950	BEHAVIORAL HEALTH @ CASIMIR	14,188	0	417,166	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.20	09921	OPT	0	0	0	0	0	99.20
99.30	09931	OOT	0	0	0	0	0	99.30
99.40	09941	OSP	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	261,837	0	42,232,552	1,231	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	1,798	0	0	2	0	190.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0133

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

Worksheet B-1

Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	DATA PROCESSING (MACHINE TI ME)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5.01	5.02	
190.01	19001	SISTERS & PRIESTS MAINTENANCE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	SEASON HOSPICE	2,028	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,999,803	0	6,618,964	343,582	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	26.348430	0.000000	0.156727	278.655312	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			57,440	7,479	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001360	6.065693	0.000000	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: 14-0133

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

Worksheet B-1

Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description			PURCHASING RECEIVING AND STORES (COSTED REQ VISITN)	ADMITTING (GROSS CHARGES)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			5.03	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	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES	5,367,601					5.03
5.04	00570	ADMITTING	25,123	431,951,837				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	431,951,837			5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	123,506	0	0	-14,349,237	77,803,312	5.06
7.00	00700	OPERATION OF PLANT	224,436	0	0	0	8,253,789	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	11,177	0	0	0	1,057,622	8.00
9.00	00900	HOUSEKEEPING	10,485	0	0	0	1,912,303	9.00
10.00	01000	DIETARY	78,371	0	0	0	1,351,090	10.00
11.00	01100	CAFETERIA	0	0	0	0	1,023,767	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,334	0	0	0	1,574,820	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,401	0	0	0	570,936	14.00
15.00	01500	PHARMACY	56,660	0	0	0	2,242,683	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	84,242	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	1,250,768	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	297,449	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,045,180	70,715,870	70,715,870	0	17,401,625	30.00
31.00	03100	INTENSIVE CARE UNIT	630,639	25,715,619	25,715,619	0	6,908,348	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	378,336	11,440,942	11,440,942	0	2,141,020	50.00
51.00	05100	RECOVERY ROOM	447	419,275	419,275	0	129,493	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	477,417	25,485,959	25,485,959	0	3,130,307	54.00
54.02	03630	ULTRA SOUND	15,510	7,443,286	7,443,286	0	602,146	54.02
56.00	05600	RADIOISOTOPE	134,434	3,171,565	3,171,565	0	1,031,017	56.00
57.00	05700	CT SCAN	105,271	43,015,868	43,015,868	0	1,292,954	57.00
59.00	05900	CARDIAC CATHETERIZATION	62,479	450,424	450,424	0	173,482	59.00
60.00	06000	LABORATORY	725,521	51,556,619	51,556,619	0	4,559,076	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	158,706	19,775,792	19,775,792	0	2,204,663	65.00
66.00	06600	PHYSICAL THERAPY	1,614	1,188,289	1,188,289	0	387,275	66.00
67.00	06700	OCCUPATIONAL THERAPY	444	1,850,466	1,850,466	0	353,581	67.00
68.00	06800	SPEECH PATHOLOGY	122	690,342	690,342	0	158,605	68.00
69.00	06900	ELECTROCARDIOLOGY	103,528	14,232,841	14,232,841	0	734,241	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,549	371,094	371,094	0	113,752	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	17,671,706	17,671,706	0	2,200,840	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	964,253	964,253	0	60,819	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	28,473,425	28,473,425	0	2,634,655	73.00
74.00	07400	RENAL DIALYSIS	75,890	2,975,435	2,975,435	0	753,359	74.00
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	32,838	1,064,772	1,064,772	0	510,022	90.00
91.00	09100	EMERGENCY	872,806	101,775,971	101,775,971	0	9,539,781	91.00
91.01	04950	BEHAVIORAL HEALTH @ CASIMIR	913	1,502,024	1,502,024	0	1,055,594	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.20	09921	OPT	0	0	0	0	0	99.20
99.30	09931	OOT	0	0	0	0	0	99.30
99.40	09941	OSP	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,366,137	431,951,837	431,951,837	-14,349,237	77,696,124	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	47,931	190.00
190.01	19001	SISTERS & PRIESTS MAINTENANCE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	1,464	0	0	0	5,822	192.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0133

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

Worksheet B-1

Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description			PURCHASING RECEIVING AND STORES (COSTED REQ UISITN)	ADMITTING (GROSS CHARGES)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
194.00	07950	SEASON HOSPICE	0	0	0	0	53,435	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	385,620	725,591	3,812,006		14,349,237	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.071842	0.001680	0.008825		0.184430	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	27,929	1,374	58,757		1,215,694	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.005203	0.000003	0.000136		0.015625	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: 14-0133

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

Worksheet B-1

Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL					5.06
7.00	00700	OPERATION OF PLANT	199,198				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	16,040	536,259			8.00
9.00	00900	HOUSEKEEPING	0	0	183,158		9.00
10.00	01000	DIETARY	9,917	0	9,917	74,383	10.00
11.00	01100	CAFETERIA	7,513	0	7,513	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	41,227	12.00
13.00	01300	NURSING ADMINISTRATION	1,160	0	1,160	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,030	0	6,030	0	14.00
15.00	01500	PHARMACY	0	0	0	2,099	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,330	0	2,330	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	54,493	296,578	54,493	63,294	30.00
31.00	03100	INTENSIVE CARE UNIT	12,430	29,847	12,430	11,089	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	15,665	45,736	15,665	0	50.00
51.00	05100	RECOVERY ROOM	1,099	11,735	1,099	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,645	12,918	13,645	0	54.00
54.02	03630	ULTRA SOUND	530	8,718	530	0	54.02
56.00	05600	RADIOISOTOPE	1,150	6,253	1,150	0	56.00
57.00	05700	CT SCAN	1,020	8,460	1,020	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	6,973	0	0	59.00
60.00	06000	LABORATORY	8,700	0	8,700	0	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,590	0	1,590	0	65.00
66.00	06600	PHYSICAL THERAPY	4,460	0	4,460	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,880	0	1,880	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,500	0	1,500	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,550	34	1,550	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,882	6,417	1,882	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,250	0	2,250	0	73.00
74.00	07400	RENAL DIALYSIS	0	395	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	291	90.00
91.00	09100	EMERGENCY	14,350	102,195	14,350	0	91.00
91.01	04950	BEHAVIORAL HEALTH @ CASIMIR	14,188	0	14,188	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				866	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
99.20	09921	OPT	0	0	0	0	99.20
99.30	09931	OOT	0	0	0	0	99.30
99.40	09941	OSP	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	195,372	536,259	179,332	74,383	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	1,798	0	1,798	0	190.00
190.01	19001	SISTERS & PRIESTS MAINTENANCE	0	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	SEASON HOSPICE	2,028	0	2,028	0	194.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0133

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

Worksheet B-1

Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	9,776,035	2,039,874	2,264,989	2,209,605	1,674,203	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	49.076974	3.803897	12.366312	29.705780	40.609382	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	523,586	481,373	31,399	311,338	235,446	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	2.628470	0.897650	0.171431	4.185607	5.710966	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: 14-0133

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

Worksheet B-1

Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description			MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			12.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
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	0					12.00
13.00	01300	NURSING ADMINISTRATION	0	17,658				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	2,202,290			14.00
15.00	01500	PHARMACY	0	0	0	2,939,715		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	431,951,837	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
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	8,465	38,173	49,967	70,715,870	30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,475	19,266	38,666	25,715,619	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	678	27,250	15,394	11,440,942	50.00
51.00	05100	RECOVERY ROOM	0	106	0	0	419,275	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	258	1,704	4,228	25,485,959	54.00
54.02	03630	ULTRA SOUND	0	0	25	0	7,443,286	54.02
56.00	05600	RADIOISOTOPE	0	0	334	430,857	3,171,565	56.00
57.00	05700	CT SCAN	0	0	168	1,246	43,015,868	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	361	25	450,424	59.00
60.00	06000	LABORATORY	0	0	1,261	4,213	51,556,619	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	101	9,157	19,775,792	65.00
66.00	06600	PHYSICAL THERAPY	0	0	3	0	1,188,289	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	1,850,466	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	690,342	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	289	159	14,232,841	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	371,094	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	2,033,466	0	17,671,706	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	50,689	0	964,253	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,270,128	28,473,425	73.00
74.00	07400	RENAL DIALYSIS	0	427	1,798	1,642	2,975,435	74.00
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	120	8,215	396	1,064,772	90.00
91.00	09100	EMERGENCY	0	4,129	19,027	113,637	101,775,971	91.00
91.01	04950	BEHAVIORAL HEALTH @ CASIMIR	0	0	3	0	1,502,024	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.20	09921	OPT	0	0	0	0	0	99.20
99.30	09931	OOT	0	0	0	0	0	99.30
99.40	09941	OSP	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	17,658	2,202,133	2,939,715	431,951,837	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	SISTERS & PRIESTS MAINTENANCE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	157	0	0	192.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0133

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

Worksheet B-1

Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description			MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			12.00	13.00	14.00	15.00	16.00	
194.00	07950	SEASON HOSPICE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	1,954,731	1,075,001	2,741,540	242,942	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	110.699456	0.488129	0.932587	0.000562	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	62,616	189,249	50,276	69,728	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	3.546041	0.085933	0.017102	0.000161	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: 14-0133

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

Worksheet B-1

Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description		INTERNS & RESIDENTS					
		SOCIAL SERVICE	NONPHYSICIAN			SERVICES-SALAR	SERVICES-OTHER
		(TIME SPENT)	ANESTHETISTS			Y & FRINGES	PRGM. COSTS
		(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)		
		17.00	19.00	21.00	22.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL					5.06
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	10,000				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0			19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0		100		21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0			0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,500	0	60	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,400	0		0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	800	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.02	03630	ULTRA SOUND	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	20	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	20	0	90.00
91.00	09100	EMERGENCY	300	0	0	0	91.00
91.01	04950	BEHAVIORAL HEALTH @ CASIMIR	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
99.20	09921	OPT	0	0	0	0	99.20
99.30	09931	OOT	0	0	0	0	99.30
99.40	09941	OSP	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,000	0	100	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.01	19001	SISTERS & PRIESTS MAINTENANCE	0	0	0	0	190.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0133

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

Worksheet B-1

Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description			SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	INTERNS & RESIDENTS			
					SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)		
					21.00	22.00		
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	SEASON HOSPICE	0	0	0	0		194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,481,447	0	352,308	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	148.144700	0.000000	3,523.080000	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	19,543	0	4,648	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.954300	0.000000	46.480000	0.000000		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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/26/2021 9:13 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	29,803,615		29,803,615	0	29,803,615	30.00
31.00	03100	INTENSIVE CARE UNIT	10,194,193		10,194,193	0	10,194,193	31.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
43.00	04300	NURSERY	0		0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,970,812		3,970,812	0	3,970,812	50.00
51.00	05100	RECOVERY ROOM	281,775		281,775	0	281,775	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,724,323		4,724,323	0	4,724,323	54.00
54.02	03630	ULTRA SOUND	798,107		798,107	0	798,107	54.02
56.00	05600	RADIOISOTOPE	1,727,005		1,727,005	0	1,727,005	56.00
57.00	05700	CT SCAN	1,679,139		1,679,139	0	1,679,139	57.00
59.00	05900	CARDIAC CATHETERIZATION	232,454		232,454	0	232,454	59.00
60.00	06000	LABORATORY	5,967,983		5,967,983	0	5,967,983	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,805,255	0	2,805,255	0	2,805,255	65.00
66.00	06600	PHYSICAL THERAPY	745,467	0	745,467	0	745,467	66.00
67.00	06700	OCCUPATIONAL THERAPY	546,960	0	546,960	0	546,960	67.00
68.00	06800	SPEECH PATHOLOGY	284,876	0	284,876	0	284,876	68.00
69.00	06900	ELECTROCARDIOLOGY	995,606		995,606	0	995,606	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	277,950		277,950	0	277,950	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,609,265		3,609,265	0	3,609,265	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	97,321		97,321	0	97,321	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,391,906		5,391,906	0	5,391,906	73.00
74.00	07400	RENAL DIALYSIS	964,322		964,322	0	964,322	74.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	634,163		634,163	0	634,163	90.00
91.00	09100	EMERGENCY	13,547,581		13,547,581	0	13,547,581	91.00
91.01	04950	BEHAVIORAL HEALTH @ CASIMIR	2,158,047		2,158,047	0	2,158,047	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0		0	0	0	94.00
99.20	09921	OPT	0		0	0	0	99.20
99.30	09931	OOT	0		0	0	0	99.30
99.40	09941	OSP	0		0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	91,438,125	0	91,438,125	0	91,438,125	200.00
201.00		Less Observation Beds	0		0	0	0	201.00
202.00		Total (see instructions)	91,438,125	0	91,438,125	0	91,438,125	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/26/2021 9:13 am

			Title XVIII			Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	70,715,870		70,715,870			30.00
31.00	03100	INTENSIVE CARE UNIT	25,715,619		25,715,619			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
43.00	04300	NURSERY	0		0			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,991,287	8,449,655	11,440,942	0.347070	0.000000	50.00
51.00	05100	RECOVERY ROOM	110,509	308,766	419,275	0.672053	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,850,879	16,635,080	25,485,959	0.185370	0.000000	54.00
54.02	03630	ULTRA SOUND	3,128,751	4,314,535	7,443,286	0.107225	0.000000	54.02
56.00	05600	RADIOISOTOPE	2,063,058	1,108,507	3,171,565	0.544528	0.000000	56.00
57.00	05700	CT SCAN	14,167,576	28,848,292	43,015,868	0.039035	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	328,829	121,595	450,424	0.516078	0.000000	59.00
60.00	06000	LABORATORY	28,869,330	22,687,289	51,556,619	0.115756	0.000000	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	19,187,232	588,560	19,775,792	0.141853	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,086,425	101,864	1,188,289	0.627345	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,766,148	84,318	1,850,466	0.295580	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	682,614	7,728	690,342	0.412659	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	7,712,521	6,520,320	14,232,841	0.069951	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	266,876	104,218	371,094	0.749002	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	15,581,921	2,089,785	17,671,706	0.204240	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	465,278	498,975	964,253	0.100929	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,253,670	6,219,755	28,473,425	0.189366	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,851,137	124,298	2,975,435	0.324094	0.000000	74.00
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	1,064,772	1,064,772	0.595586	0.000000	90.00
91.00	09100	EMERGENCY	28,287,432	73,488,539	101,775,971	0.133112	0.000000	91.00
91.01	04950	BEHAVIORAL HEALTH @ CASIMIR	0	1,502,024	1,502,024	1.436759	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								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	0.000000	94.00
99.20	09921	OPT	0	0	0			99.20
99.30	09931	OOT	0	0	0			99.30
99.40	09941	OSP	0	0	0			99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	257,082,962	174,868,875	431,951,837			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	257,082,962	174,868,875	431,951,837			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0133	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepared: 11/26/2021 9:13 am
			Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio		
			11.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.347070		50.00
51.00	05100	RECOVERY ROOM	0.672053		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.185370		54.00
54.02	03630	ULTRA SOUND	0.107225		54.02
56.00	05600	RADIOISOTOPE	0.544528		56.00
57.00	05700	CT SCAN	0.039035		57.00
59.00	05900	CARDIAC CATHETERIZATION	0.516078		59.00
60.00	06000	LABORATORY	0.115756		60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0.141853		65.00
66.00	06600	PHYSICAL THERAPY	0.627345		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.295580		67.00
68.00	06800	SPEECH PATHOLOGY	0.412659		68.00
69.00	06900	ELECTROCARDIOLOGY	0.069951		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.749002		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.204240		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.100929		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.189366		73.00
74.00	07400	RENAL DIALYSIS	0.324094		74.00
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	0.595586		90.00
91.00	09100	EMERGENCY	0.133112		91.00
91.01	04950	BEHAVIORAL HEALTH @ CASIMIR	1.436759		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		94.00
99.20	09921	OPT			99.20
99.30	09931	OOT			99.30
99.40	09941	OSP			99.40
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/26/2021 9:13 am

			Title XIX		Hospital		Cost
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
					Total Costs	RCE Disallowance	Total Costs
			1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	30,014,999		30,014,999	0	30,014,999
31.00	03100	INTENSIVE CARE UNIT	10,194,193		10,194,193	0	10,194,193
41.00	04100	SUBPROVIDER - IRF	0		0	0	0
43.00	04300	NURSERY	0		0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,970,812		3,970,812	0	3,970,812
51.00	05100	RECOVERY ROOM	281,775		281,775	0	281,775
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0
53.00	05300	ANESTHESIOLOGY	0		0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,724,323		4,724,323	0	4,724,323
54.02	03630	ULTRA SOUND	798,107		798,107	0	798,107
56.00	05600	RADIOISOTOPE	1,727,005		1,727,005	0	1,727,005
57.00	05700	CT SCAN	1,679,139		1,679,139	0	1,679,139
59.00	05900	CARDIAC CATHETERIZATION	232,454		232,454	0	232,454
60.00	06000	LABORATORY	5,967,983		5,967,983	0	5,967,983
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0		0	0	0
65.00	06500	RESPIRATORY THERAPY	2,805,255	0	2,805,255	0	2,805,255
66.00	06600	PHYSICAL THERAPY	745,467	0	745,467	0	745,467
67.00	06700	OCCUPATIONAL THERAPY	546,960	0	546,960	0	546,960
68.00	06800	SPEECH PATHOLOGY	284,876	0	284,876	0	284,876
69.00	06900	ELECTROCARDIOLOGY	1,066,068		1,066,068	0	1,066,068
70.00	07000	ELECTROENCEPHALOGRAPHY	277,950		277,950	0	277,950
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,609,265		3,609,265	0	3,609,265
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	97,321		97,321	0	97,321
73.00	07300	DRUGS CHARGED TO PATIENTS	5,391,906		5,391,906	0	5,391,906
74.00	07400	RENAL DIALYSIS	964,322		964,322	0	964,322
76.97	07697	CARDIAC REHABILITATION	0		0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0
76.99	07699	LITHOTRIPSY	0		0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	704,625		704,625	0	704,625
91.00	09100	EMERGENCY	13,547,581		13,547,581	0	13,547,581
91.01	04950	BEHAVIORAL HEALTH @ CASIMIR	2,158,047		2,158,047	0	2,158,047
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0	0	0
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0		0	0	0
99.20	09921	OPT	0		0	0	0
99.30	09931	OOT	0		0	0	0
99.40	09941	OSP	0		0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
200.00		Subtotal (see instructions)	91,790,433	0	91,790,433	0	91,790,433
201.00		Less Observation Beds	0		0	0	0
202.00		Total (see instructions)	91,790,433	0	91,790,433	0	91,790,433

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/26/2021 9:13 am

			Title XIX			Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	70,715,870		70,715,870			30.00
31.00	03100	INTENSIVE CARE UNIT	25,715,619		25,715,619			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
43.00	04300	NURSERY	0		0			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,991,287	8,449,655	11,440,942	0.347070	0.000000	50.00
51.00	05100	RECOVERY ROOM	110,509	308,766	419,275	0.672053	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,850,879	16,635,080	25,485,959	0.185370	0.000000	54.00
54.02	03630	ULTRA SOUND	3,128,751	4,314,535	7,443,286	0.107225	0.000000	54.02
56.00	05600	RADIOISOTOPE	2,063,058	1,108,507	3,171,565	0.544528	0.000000	56.00
57.00	05700	CT SCAN	14,167,576	28,848,292	43,015,868	0.039035	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	328,829	121,595	450,424	0.516078	0.000000	59.00
60.00	06000	LABORATORY	28,869,330	22,687,289	51,556,619	0.115756	0.000000	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	19,187,232	588,560	19,775,792	0.141853	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,086,425	101,864	1,188,289	0.627345	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,766,148	84,318	1,850,466	0.295580	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	682,614	7,728	690,342	0.412659	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	7,712,521	6,520,320	14,232,841	0.074902	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	266,876	104,218	371,094	0.749002	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	15,581,921	2,089,785	17,671,706	0.204240	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	465,278	498,975	964,253	0.100929	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,253,670	6,219,755	28,473,425	0.189366	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,851,137	124,298	2,975,435	0.324094	0.000000	74.00
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	1,064,772	1,064,772	0.661761	0.000000	90.00
91.00	09100	EMERGENCY	28,287,432	73,488,539	101,775,971	0.133112	0.000000	91.00
91.01	04950	BEHAVIORAL HEALTH @ CASIMIR	0	1,502,024	1,502,024	1.436759	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								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	0.000000	94.00
99.20	09921	OPT	0	0	0			99.20
99.30	09931	OOT	0	0	0			99.30
99.40	09941	OSP	0	0	0			99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	257,082,962	174,868,875	431,951,837			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	257,082,962	174,868,875	431,951,837			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.02	03630	ULTRA SOUND	0.000000			54.02
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
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
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
91.00	09100	EMERGENCY	0.000000			91.00
91.01	04950	BEHAVIORAL HEALTH @ CASIMIR	0.000000			91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0.000000			94.00
99.20	09921	OPT				99.20
99.30	09931	OOT				99.30
99.40	09941	OSP				99.40
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part I
Date/Time Prepared:
11/26/2021 9:13 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	2,581,057	0	2,581,057	25,365	101.76	30.00
31.00	INTENSIVE CARE UNIT	600,442		600,442	4,444	135.11	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
43.00	NURSERY	0		0	0	0.00	43.00
200.00	Total (lines 30 through 199)	3,181,499		3,181,499	29,809		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	5,515	561,206				
31.00	INTENSIVE CARE UNIT	1,067	144,162				
41.00	SUBPROVIDER - IRF	0	0				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	6,582	705,368				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part II
Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description		Title XVIII		Hospital		PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	555,042	11,440,942	0.048514	939,619	45,585	50.00
51.00	05100 RECOVERY ROOM	45,808	419,275	0.109255	19,768	2,160	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	483,764	25,485,959	0.018982	1,957,623	37,160	54.00
54.02	03630 ULTRA SOUND	37,689	7,443,286	0.005063	943,262	4,776	54.02
56.00	05600 RADIOISOTOPE	65,820	3,171,565	0.020753	1,968,095	40,844	56.00
57.00	05700 CT SCAN	75,721	43,015,868	0.001760	3,647,501	6,420	57.00
59.00	05900 CARDIAC CATHETERIZATION	9,515	450,424	0.021125	246,597	5,209	59.00
60.00	06000 LABORATORY	344,703	51,556,619	0.006686	5,652,324	37,791	60.00
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	100,513	19,775,792	0.005083	3,964,309	20,151	65.00
66.00	06600 PHYSICAL THERAPY	138,470	1,188,289	0.116529	321,125	37,420	66.00
67.00	06700 OCCUPATIONAL THERAPY	62,846	1,850,466	0.033962	354,975	12,056	67.00
68.00	06800 SPEECH PATHOLOGY	47,167	690,342	0.068324	201,059	13,737	68.00
69.00	06900 ELECTROCARDIOLOGY	65,166	14,232,841	0.004579	2,013,894	9,222	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	63,001	371,094	0.169771	80,842	13,725	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	214,431	17,671,706	0.012134	3,798,260	46,088	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	5,595	964,253	0.005802	192,946	1,119	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	154,249	28,473,425	0.005417	4,924,758	26,677	73.00
74.00	07400 RENAL DIALYSIS	18,504	2,975,435	0.006219	957,359	5,954	74.00
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	11,593	1,064,772	0.010888	0	0	90.00
91.00	09100 EMERGENCY	764,809	101,775,971	0.007515	4,359,848	32,764	91.00
91.01	04950 BEHAVIORAL HEALTH @ CASIMIR	436,020	1,502,024	0.290288	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00	Total (lines 50 through 199)	3,700,426	335,520,348		36,544,164	398,858	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0133		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part III Date/Time Prepared: 11/26/2021 9:13 am	
					Title XVIII		Hospital		PPS	
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF		0	0	0	0	0	0	41.00
43.00	04300	NURSERY		0	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
					4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	25,365	0.00	5,515	30.00	
31.00	03100	INTENSIVE CARE UNIT			0	4,444	0.00	1,067	31.00	
41.00	04100	SUBPROVIDER - IRF		0	0	0	0.00	0	41.00	
43.00	04300	NURSERY			0	0	0.00	0	43.00	
200.00		Total (lines 30 through 199)			0	29,809		6,582	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
41.00	04100	SUBPROVIDER - IRF		0						41.00
43.00	04300	NURSERY		0						43.00
200.00		Total (lines 30 through 199)		0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description			Title XVIII		Hospital	PPS	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	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	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.02	03630	ULTRA SOUND	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
91.01	04950	BEHAVIORAL HEALTH @ CASIMIR	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0133		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/26/2021 9:13 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	11,440,942	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	419,275	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	25,485,959	0.000000	54.00
54.02	03630	ULTRA SOUND		0	0	0	7,443,286	0.000000	54.02
56.00	05600	RADIOISOTOPE		0	0	0	3,171,565	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	43,015,868	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	450,424	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	51,556,619	0.000000	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.		0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY		0	0	0	19,775,792	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	1,188,289	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	1,850,466	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	690,342	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	14,232,841	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	371,094	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	17,671,706	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	964,253	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	28,473,425	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	2,975,435	0.000000	74.00
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	1,064,772	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	101,775,971	0.000000	91.00
91.01	04950	BEHAVIORAL HEALTH @ CASIMIR		0	0	0	1,502,024	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS		0	0	0	0	0.000000	94.00
200.00		Total (lines 50 through 199)		0	0	0	335,520,348		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0133	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part IV Date/Time Prepared: 11/26/2021 9:13 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	939,619	0	954,240	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	19,768	0	48,833	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,957,623	0	2,494,836	0	54.00
54.02	03630	ULTRA SOUND	0.000000	943,262	0	312,854	0	54.02
56.00	05600	RADIOISOTOPE	0.000000	1,968,095	0	1,048,200	0	56.00
57.00	05700	CT SCAN	0.000000	3,647,501	0	3,049,701	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	246,597	0	12,982	0	59.00
60.00	06000	LABORATORY	0.000000	5,652,324	0	1,849,010	0	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	3,964,309	0	119,958	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	321,125	0	4,628	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	354,975	0	4,587	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	201,059	0	447	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,013,894	0	921,288	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	80,842	0	12,662	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	3,798,260	0	340,765	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	192,946	0	238,024	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	4,924,758	0	938,590	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	957,359	0	53,479	0	74.00
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	126,848	0	90.00
91.00	09100	EMERGENCY	0.000000	4,359,848	0	4,542,405	0	91.00
91.01	04950	BEHAVIORAL HEALTH @ CASIMIR	0.000000	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00
200.00		Total (lines 50 through 199)		36,544,164	0	17,074,337	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0133	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part V Date/Time Prepared: 11/26/2021 9:13 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	0.347070	954,240	0	0	331,188	50.00
51.00	05100	RECOVERY ROOM	0.672053	48,833	0	0	32,818	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.185370	2,494,836	0	0	462,468	54.00
54.02	03630	ULTRA SOUND	0.107225	312,854	0	0	33,546	54.02
56.00	05600	RADIOISOTOPE	0.544528	1,048,200	0	0	570,774	56.00
57.00	05700	CT SCAN	0.039035	3,049,701	0	0	119,045	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.516078	12,982	0	0	6,700	59.00
60.00	06000	LABORATORY	0.115756	1,849,010	5,931	0	214,034	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.141853	119,958	0	0	17,016	65.00
66.00	06600	PHYSICAL THERAPY	0.627345	4,628	0	0	2,903	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.295580	4,587	0	0	1,356	67.00
68.00	06800	SPEECH PATHOLOGY	0.412659	447	0	0	184	68.00
69.00	06900	ELECTROCARDIOLOGY	0.069951	921,288	0	0	64,445	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.749002	12,662	0	0	9,484	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.204240	340,765	0	0	69,598	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.100929	238,024	0	0	24,024	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.189366	938,590	0	15,869	177,737	73.00
74.00	07400	RENAL DIALYSIS	0.324094	53,479	0	0	17,332	74.00
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	0.595586	126,848	0	0	75,549	90.00
91.00	09100	EMERGENCY	0.133112	4,542,405	0	0	604,649	91.00
91.01	04950	BEHAVIORAL HEALTH @ CASIMIR	1.436759	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		0	0		94.00
200.00		Subtotal (see instructions)		17,074,337	5,931	15,869	2,834,850	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		17,074,337	5,931	15,869	2,834,850	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/26/2021 9:13 am

			Title XVIII		Hospital	PPS
	Cost Center Description	Costs				
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		6.00	7.00			
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.02	03630	ULTRA SOUND	0	0		54.02
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	687	0		60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
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	3,005		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
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
91.00	09100	EMERGENCY	0	0		91.00
91.01	04950	BEHAVIORAL HEALTH @ CASIMIR	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0	0		94.00
200.00		Subtotal (see instructions)	687	3,005		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	687	3,005		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0133	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/26/2021 9:13 am	
		Title XVIII	Hospital	PPS	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			25,365	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			25,365	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)			25,365	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)			5,515	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)			29,803,615	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)			29,803,615	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)			29,803,615	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)			1,174.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			6,480,070	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)			6,480,070	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0133

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

Worksheet D-1

Date/Time Prepared:
11/26/2021 9:13 am

		Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	10,194,193	4,444	2,293.92	1,067	2,447,613
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					6,570,599
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					15,498,282
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					705,368
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					398,858
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,104,226
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					14,394,056
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					0
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0133

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

Worksheet D-1

Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description		Title XVIII		Hospital		PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,581,057	29,803,615	0.086602	0	0	90.00
91.00	Nursing School cost	0	29,803,615	0.000000	0	0	91.00
92.00	Allied health cost	0	29,803,615	0.000000	0	0	92.00
93.00	All other Medical Education	0	29,803,615	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0133

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

Worksheet D-1

Date/Time Prepared:
11/26/2021 9:13 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)	25,365	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	25,365	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)	25,365	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)	1,846	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)	30,014,999	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)	30,014,999	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)	30,014,999	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)	1,183.32	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,184,409	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)	2,184,409	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0133

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

Worksheet D-1

Date/Time Prepared:
11/26/2021 9:13 am

			Title XIX		Hospital	Cost	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	10,194,193	4,444	2,293.92	497	1,140,078	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,983,585	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,308,072	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)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0133

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

Worksheet D-1

Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description		Title XIX		Hospital		Cost	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,581,057	30,014,999	0.085992	0	0	90.00
91.00	Nursing School cost	0	30,014,999	0.000000	0	0	91.00
92.00	Allied health cost	0	30,014,999	0.000000	0	0	92.00
93.00	All other Medical Education	0	30,014,999	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0133	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/26/2021 9:13 am
			Title XVIII	Hospital	PPS
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		17,979,537	30.00
31.00	03100	INTENSIVE CARE UNIT		5,789,225	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.347070	939,619	50.00
51.00	05100	RECOVERY ROOM	0.672053	19,768	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.185370	1,957,623	54.00
54.02	03630	ULTRA SOUND	0.107225	943,262	54.02
56.00	05600	RADIOISOTOPE	0.544528	1,968,095	56.00
57.00	05700	CT SCAN	0.039035	3,647,501	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.516078	246,597	59.00
60.00	06000	LABORATORY	0.115756	5,652,324	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.141853	3,964,309	65.00
66.00	06600	PHYSICAL THERAPY	0.627345	321,125	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.295580	354,975	67.00
68.00	06800	SPEECH PATHOLOGY	0.412659	201,059	68.00
69.00	06900	ELECTROCARDIOLOGY	0.069951	2,013,894	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.749002	80,842	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.204240	3,798,260	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.100929	192,946	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.189366	4,924,758	73.00
74.00	07400	RENAL DIALYSIS	0.324094	957,359	74.00
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	0.595586	0	90.00
91.00	09100	EMERGENCY	0.133112	4,359,848	91.00
91.01	04950	BEHAVIORAL HEALTH @ CASIMIR	1.436759	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	94.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		36,544,164	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)		36,544,164	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0133	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/26/2021 9:13 am
			Title XIX	Hospital	Cost
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		4,910,813	30.00
31.00	03100	INTENSIVE CARE UNIT		2,529,197	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.347070	532,067	50.00
51.00	05100	RECOVERY ROOM	0.672053	54,709	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.185370	569,852	54.00
54.02	03630	ULTRA SOUND	0.107225	101,324	54.02
56.00	05600	RADIOISOTOPE	0.544528	0	56.00
57.00	05700	CT SCAN	0.039035	1,070,402	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.516078	15,793	59.00
60.00	06000	LABORATORY	0.115756	2,689,749	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.141853	1,772,819	65.00
66.00	06600	PHYSICAL THERAPY	0.627345	76,012	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.295580	121,484	67.00
68.00	06800	SPEECH PATHOLOGY	0.412659	77,545	68.00
69.00	06900	ELECTROCARDIOLOGY	0.074902	631,723	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.749002	15,000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.204240	1,629,841	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.100929	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.189366	2,374,886	73.00
74.00	07400	RENAL DIALYSIS	0.324094	84,533	74.00
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	0.661761	0	90.00
91.00	09100	EMERGENCY	0.133112	366,188	91.00
91.01	04950	BEHAVIORAL HEALTH @ CASIMIR	1.436759	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	94.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		12,183,927	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)		12,183,927	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A
Date/Time Prepared:
11/26/2021 9:13 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)			2,534,046	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			7,782,644	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)			8,631	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			127,001	2.04
3.00	Managed Care Simulated Payments			7,828,047	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			155.00	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).			5.00	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)			5.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			4.57	10.00
11.00	FTE count for residents in dental and podiatric programs.			0.00	11.00
12.00	Current year allowable FTE (see instructions)			4.57	12.00
13.00	Total allowable FTE count for the prior year.			0.00	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.			0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.			1.52	15.00
16.00	Adjustment for residents in initial years of the program			0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00	17.00
18.00	Adjusted rolling average FTE count			1.52	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.009806	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.030400	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.009806	21.00
22.00	IME payment adjustment (see instructions)			55,153	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			41,849	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)			-0.43	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)			55,153	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			41,849	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			17.14	30.00
31.00	Percentage of Medicaid patient days (see instructions)			43.69	31.00
32.00	Sum of lines 30 and 31			60.83	32.00
33.00	Allowable disproportionate share percentage (see instructions)			39.40	33.00
34.00	Disproportionate share adjustment (see instructions)			1,016,195	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0133	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/26/2021 9:13 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)	2,241,707	1,847,944		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	563,489	1,382,160		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,945,649			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)	13,469,319			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)			13,511,168	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			898,379	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			46,792	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			258,985	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)			14,715,324	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			14,715,324	61.00
62.00	Deductibles billed to program beneficiaries			1,061,368	62.00
63.00	Coinsurance billed to program beneficiaries			64,072	63.00
64.00	Allowable bad debts (see instructions)			1,064,869	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			692,165	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			741,257	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			14,282,049	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)				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)			-67,676	70.93
70.94	HRR adjustment amount (see instructions)			-83,724	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A
Date/Time Prepared:
11/26/2021 9:13 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	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	0	70.97
70.98	Low Volume Payment-3		0	0	70.98
70.99	HAC adjustment amount (see instructions)		0	0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		14,130,649	0	71.00
71.01	Sequestration adjustment (see instructions)		0	0	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	0	71.03
72.00	Interim payments		12,790,910	0	72.00
72.01	Interim payments-PARHM		0	0	72.01
73.00	Tentative settlement (for contractor use only)		0	0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		1,339,739	0	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		398,773	0	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	0	94.00
95.00	Time value of money for operating expenses (see instructions)		0	0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	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	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	0	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	0	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

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/26/2021 9:13 am

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,534,046	0	2,534,046		2,534,046	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	7,782,644	0		7,782,644	7,782,644	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	8,631	0	8,631		8,631	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	127,001	0		127,001	127,001	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	7,828,047	0	1,454,794	6,373,253	7,828,047	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.009806	0.009806	0.009806	0.009806		5.00
6.00	IME payment adjustment (see instructions)	22.00	55,153	0	13,547	41,606	55,153	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	41,849	0	7,777	34,072	41,849	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	55,153	0	13,547	41,606	55,153	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	41,849	0	7,777	34,072	41,849	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.3940	0.3940	0.3940	0.3940		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	1,016,195	0	249,604	766,591	1,016,195	11.00
11.01	Uncompensated care payments	36.00	1,945,649	0	563,489	1,382,160	1,945,649	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	13,469,319	0	3,369,317	10,100,002	13,469,319	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	13,511,168	0	3,377,094	10,134,074	13,511,168	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	898,379	0	225,018	673,361	898,379	16.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/26/2021 9:13 am

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	258,985	0	0	258,985	258,985	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	3,602,112	11,066,420	14,668,532	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	783,375	0	197,453	585,922	783,375	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	8,152	0	632	7,520	8,152	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0053	0.0053	0.0053	0.0053		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	4,152	0	1,047	3,105	4,152	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1311	0.1311	0.1311	0.1311		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	102,700	0	25,886	76,814	102,700	25.00
26.00	Total prospective capital payments (see instructions)	12.00	898,379	0	225,018	673,361	898,379	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		N					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/26/2021 9:13 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	2,534,046	2,534,046		2,534,046	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	7,782,644		7,782,644	7,782,644	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	8,631	8,631		8,631	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	127,001		127,001	127,001	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	7,828,047	1,454,794	6,373,253	7,828,047	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.009806	0.009806	0.009806		5.00
6.00	IME payment adjustment (see instructions)	22.00	55,153	13,547	41,606	55,153	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	41,849	7,777	34,072	41,849	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	55,153	13,547	41,606	55,153	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	41,849	7,777	34,072	41,849	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.3940	0.3940	0.3940		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	1,016,195	249,604	766,591	1,016,195	11.00
11.01	Uncompensated care payments	36.00	1,945,649	563,489	1,382,160	1,945,649	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	13,469,319	3,369,317	10,100,002	13,469,319	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	13,511,168	3,377,094	10,134,074	13,511,168	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	898,379	225,018	673,361	898,379	16.00
17.00	Special add-on payments for new technologies	54.00	258,985	0	258,985	258,985	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			3,602,112	11,066,420	14,668,532	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/26/2021 9:13 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	783,375	197,453	585,922	783,375	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	8,152	632	7,520	8,152	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	0.0053	0.0053	0.0053		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	4,152	1,047	3,105	4,152	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1311	0.1311	0.1311		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	102,700	25,886	76,814	102,700	25.00
26.00	Total prospective capital payments (see instructions)	12.00	898,379	225,018	673,361	898,379	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	-67,676	-2,285	-65,391	-67,676	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	-83,724	-16,979	-66,745	-83,724	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0133	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/26/2021 9:13 am
		Title XVIII	Hospital	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		3,692	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		2,834,850	2.00
3.00	OPPS payments		2,149,195	3.00
4.00	Outlier payment (see instructions)		6,036	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)		3,692	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		21,800	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)		21,800	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)		21,800	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		18,108	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)		3,692	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)		2,155,231	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)		424,994	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		1,733,929	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		8,570	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		1,742,499	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,742,499	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		315,424	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		205,026	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		203,872	36.00
37.00	Subtotal (see instructions)		1,947,525	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		1,947,525	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		1,963,790	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)		-16,265	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: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part I
Date/Time Prepared:
11/26/2021 9:13 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		12,922,817		2,002,900	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	03/02/2021	131,907	03/02/2021	39,110	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)		-131,907		-39,110	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)		12,790,910		1,963,790	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		1,339,739		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		16,265	6.02	
7.00	Total Medicare program liability (see instructions)		14,130,649		1,947,525	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: 14-0133	Period: From 07/01/2020 To 06/30/2021	Worksheet E-1 Part II Date/Time Prepared: 11/26/2021 9:13 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: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet E-3
Part VII
Date/Time Prepared:
11/26/2021 9:13 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		5,308,072		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)		5,308,072	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)		5,308,072	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		7,440,010		8.00
9.00	Ancillary service charges		12,183,927	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)		19,623,937	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)		19,623,937	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		14,315,865	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		5,308,072	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		5,308,072	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		5,308,072	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		5,308,072	0	36.00
37.00	INTERIM PAYMENT RECONCILIATION		-1,383,285	0	37.00
38.00	Subtotal (line 36 ± line 37)		3,924,787	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)		3,924,787	0	40.00
41.00	Interim payments		3,924,787	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0133		Period: From 07/01/2020 To 06/30/2021		Worksheet E-4 Date/Time Prepared: 11/26/2021 9:13 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))					5.00	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)					5.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)					4.57	6.00
7.00	Enter the lesser of line 5 or line 6					4.57	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.	2.76		0.90		3.66	
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.	2.76		0.90		3.66	
10.00	Weighted dental and podiatric resident FTE count for the current year			0.00		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	2.76		0.90		11.00	
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00		0.00		12.00	
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00		0.00		13.00	
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.92		0.30		14.00	
15.00	Adjustment for residents in initial years of new programs	0.00		0.00		15.00	
15.01	Unweighted adjustment for residents in initial years of new programs	0.00		0.00		15.01	
16.00	Adjustment for residents displaced by program or hospital closure	0.00		0.00		16.00	
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00		0.00		16.01	
17.00	Adjusted rolling average FTE count	0.92		0.30		17.00	
18.00	Per resident amount	114,232.10		114,232.10		18.00	
19.00	Approved amount for resident costs	105,094		34,270		139,364	
						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	
21.00	Direct GME FTE unweighted resident count over cap (see instructions)					0.00	
22.00	Allowable additional direct GME FTE Resident Count (see instructions)					0.00	
23.00	Enter the locality adjustment national average per resident amount (see instructions)					0.00	
24.00	Multiply line 22 time line 23					0	
25.00	Total direct GME amount (sum of lines 19 and 24)					139,364	
		Inpatient Part A		Managed Care Prior to 1/1		Managed Care On or after 1/1	
		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)	6,582		1,071		4,412	
27.00	Total Inpatient Days (see instructions)	29,809		29,809		29,809	
28.00	Ratio of inpatient days to total inpatient days	0.220806		0.035929		0.148009	
29.00	Program direct GME amount	30,772		5,007		20,627	
29.01	Percent reduction for MA DGME			4.07		4.07	
30.00	Reduction for direct GME payments for Medicare Advantage			204		840	
31.00	Net Program direct GME amount					55,362	

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0133	Period: From 07/01/2020 To 06/30/2021	Worksheet E-4 Date/Time Prepared: 11/26/2021 9:13 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)		2,975,435		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)		15,498,282		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)		15,498,282		41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)		2,838,542		42.00
43.00	Primary payer payments (see instructions)		0		43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		2,838,542		44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		18,336,824		45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.845200		46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.154800		47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)		55,362		48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		46,792		49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		8,570		50.00

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

Provider CCN: 14-0133

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

Worksheet G

Date/Time Prepared:
11/26/2021 9:13 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	4,363,572	0	0	0	1.00
2.00	Temporary investments	3,439,680	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	13,603,990	0	0	0	4.00
5.00	Other receivable	1,827,044	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,893,274	0	0	0	6.00
7.00	Inventory	2,019,996	0	0	0	7.00
8.00	Prepaid expenses	404,697	0	0	0	8.00
9.00	Other current assets	3,342,512	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)	26,108,217	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,700,000	0	0	0	12.00
13.00	Land improvements	109,714	0	0	0	13.00
14.00	Accumulated depreciation	-61,841	0	0	0	14.00
15.00	Buildings	101,097,119	0	0	0	15.00
16.00	Accumulated depreciation	-33,388,402	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	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	35,671,919	0	0	0	23.00
24.00	Accumulated depreciation	-26,591,671	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)	78,536,838	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	5,530,130	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	33,777,631	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	39,307,761	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	143,952,816	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	3,528,140	0	0	0	37.00
38.00	Salaries, wages, and fees payable	6,269,393	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,193,648	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	45,837,155	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	57,828,336	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	15,067,868	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	15,067,868	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	72,896,204	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	71,056,612				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)	71,056,612	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	143,952,816	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0133

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

Worksheet G-1

Date/Time Prepared:
11/26/2021 9:13 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		69,909,932		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,146,680				2.00
3.00	Total (sum of line 1 and line 2)		71,056,612		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		71,056,612		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		71,056,612		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
11/26/2021 9:13 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	70,625,112		70,625,112	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	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)	70,625,112		70,625,112	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	25,762,050		25,762,050	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	25,762,050		25,762,050	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	96,387,162		96,387,162	17.00
18.00	Ancillary services	159,999,595		159,999,595	18.00
19.00	Outpatient services	0	175,638,667	175,638,667	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
24.20	OPT	0	0	0	24.20
24.30	OOT	0	0	0	24.30
24.40	OSP	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	256,386,757	175,638,667	432,025,424	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		105,239,398		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	EC1 2000 PROVIDER ASSESSMENT	7,523,525			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)		7,523,525		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		97,715,873		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0133

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

Worksheet G-3

Date/Time Prepared:
11/26/2021 9:13 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	432,025,424	1.00
2.00	Less contractual allowances and discounts on patients' accounts	362,413,691	2.00
3.00	Net patient revenues (line 1 minus line 2)	69,611,733	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	97,715,873	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-28,104,140	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	100	6.00
7.00	Income from investments	988,861	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	29,243	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	781	21.00
22.00	Rental of hospital space	504,541	22.00
23.00	Governmental appropriations	0	23.00
24.00	B 340B OTHER CONTRACT	1,106,836	24.00
24.01	HCH GENERAL OPS PARKING REVENUE	37,409	24.01
24.02	HCH INCIDENT COMMAND COVID-19 RESTRI	136,300	24.02
24.03	HCH GENERAL OPS OTH OPR REV	244,541	24.03
24.04	OTHER NON OPERATING REV	202,796	24.04
24.05	OTHER (SPECIFY)	0	24.05
24.50	COVID-19 PHE Funding	25,999,412	24.50
25.00	Total other income (sum of lines 6-24)	29,250,820	25.00
26.00	Total (line 5 plus line 25)	1,146,680	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,146,680	29.00

CALCULATION OF CAPITAL PAYMENT

Provider CCN: 14-0133

Period:
From 07/01/2020
To 06/30/2021Worksheet L
Parts I-III
Date/Time Prepared:
11/26/2021 9:13 am

Title XVIII		Hospital	PPS
			1.00
PART I - FULLY PROSPECTIVE METHOD			
CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier	783,375	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	8,152	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)	81.67	3.00
4.00	Number of interns & residents (see instructions)	1.52	4.00
5.00	Indirect medical education percentage (see instructions)	0.53	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)	4,152	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	17.14	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	43.69	8.00
9.00	Sum of lines 7 and 8	60.83	9.00
10.00	Allowable disproportionate share percentage (see instructions)	13.11	10.00
11.00	Disproportionate share adjustment (see instructions)	102,700	11.00
12.00	Total prospective capital payments (see instructions)	898,379	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