

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: 14-1335	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 2/23/2022 7:54 pm
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 2. ☐ Manually prepared cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report 4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		Date: 2/23/2022 Time: 7:54 pm
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)
 MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HARVARD MEMORIAL HOSPITAL (14-1335) 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.

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

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	2,440	-680,097	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
7.00	SKILLED NURSING FACILITY	0	0	-4		0	7.00
200.00	Total	0	2,440	-680,101	0	0	200.00

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

Health Financial Systems		HARVARD MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10						
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1335		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/23/2022 7:54 pm		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 901 GRANT STREET		PO Box:						1.00	
2.00	City: HARVARD		State: IL		Zip Code: 60033-		County: MC HENRY		2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		HARVARD MEMORIAL HOSPITAL	141335	16974	1	01/01/2004	N	O	O
4.00	Subprovider - IPF									3.00
5.00	Subprovider - IRF									4.00
6.00	Subprovider - (Other)									5.00
7.00	Swing Beds - SNF									6.00
8.00	Swing Beds - NF									7.00
9.00	Hospital-Based SNF		CARE CENTER	146014	99914		01/01/2002	N	P	N
10.00	Hospital-Based NF									8.00
11.00	Hospital-Based OLTC									9.00
12.00	Hospital-Based HHA									10.00
13.00	Separately Certified ASC									11.00
14.00	Hospital-Based Hospice									12.00
15.00	Hospital-Based Health Clinic - RHC									13.00
16.00	Hospital-Based Health Clinic - FQHC									14.00
17.00	Hospital-Based (CMHC) I									15.00
17.10	Hospital-Based (CORF) I									16.00
18.00	Renal Dialysis									17.00
19.00	Other									17.10
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2020	06/30/2021		20.00	
21.00	Type of Control (see instructions)					2			21.00	
						1.00	2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				N	N			22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				N	N			22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				N	N			22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				N	N	N		22.03	
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				N	N	N		22.04	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.				3	N			23.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1335

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
2/23/2022 7:54 pm

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	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.					2		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.					2		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	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N		
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.							
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: 14-1335

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
2/23/2022 7:54 pm

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N			60.00
		Y/N	IME	Direct GME	
		1.00	2.00	3.00	4.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				0.00
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				0.00
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				0.00
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).				0.00
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				0.00
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				0.00
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count
		1.00	2.00	3.00	4.00
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00
					1.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00
Teaching Hospitals that Claim Residents in Nonprovider Settings					
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)			N	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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

Health Financial Systems		HARVARD MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
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			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	N		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	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	N		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y			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)	Y			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00

Health Financial Systems		HARVARD MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1335		Period: From 07/01/2020 To 06/30/2021 Worksheet S-2 Part I Date/Time Prepared: 2/23/2022 7:54 pm	
		V		XIX	
		1.00		2.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	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	
		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	
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		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.	Y		117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2		118.00	
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	39,600		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	

Health Financial Systems		HARVARD MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1335		Period: From 07/01/2020 To 06/30/2021	
				Worksheet S-2 Part I Date/Time Prepared: 2/23/2022 7:54 pm	
		1.00	2.00		
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00	
133.00	Removed and reserved			133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00	
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0764	140.00	
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name: MERCY HOME OFFICE	Contractor's Name: NGS		Contractor's Number: 00450	
142.00	Street: 1000 MINERAL POINT AVE	PO Box:			
143.00	City: JANESVILLE	State: WI		Zip Code: 53547	
				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.			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	Y	Y	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N
161.10	CORF		N	N	N
				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
		0	1.00	2.00	3.00
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)			N	168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			9.99	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1335

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
2/23/2022 7:54 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0171.00

Health Financial Systems		HARVARD MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10				
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1335		Period: From 07/01/2020 To 06/30/2021 Worksheet S-2 Part II Date/Time Prepared: 2/23/2022 7:54 pm				
				Y/N	Date			
				1.00	2.00			
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.								
COMPLETED BY ALL HOSPITALS								
Provider Organization and Operation								
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N		1.00		
				Y/N	Date	V/I		
				1.00	2.00	3.00		
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N		2.00		
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			Y		3.00		
				Y/N	Type	Date		
				1.00	2.00	3.00		
Financial Data and Reports								
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			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	Legal Oper.			
				1.00	2.00			
Approved Educational Activities								
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider is the legal operator of the program?			N		6.00		
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N		7.00		
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N		8.00		
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N		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	Date	Y/N	Date	
				1.00	2.00	3.00	4.00	
PS&R Data								
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			N		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	10/20/2021	Y	10/20/2021	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		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		N		19.00

Health Financial Systems		HARVARD MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1335		Period: From 07/01/2020 To 06/30/2021	
		Worksheet S-2 Part II Date/Time Prepared: 2/23/2022 7:54 pm			
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		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.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		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.		Y		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		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		Y		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		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.		N		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.		N		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.		Y		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.		Y		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.		Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		Y		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JENNY	DABROWSKI		41.00
42.00	Enter the employer/company name of the cost report preparer.	STRATEGIC REIMBURSEMENT GROUP, LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	630-530-7100	JENNY.DABROWSKI@SRGROUPLLC.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1335

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part II
Date/Time Prepared:
2/23/2022 7:54 pm

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 14-1335

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/23/2022 7:54 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	10	3,650	27,533.00	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)		10	3,650	27,533.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	3	1,095	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						13.00
14.00 Total (see instructions)		13	4,745	27,533.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	12	4,380		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	46.00	33	12,045			21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		58				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: 14-1335

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/23/2022 7:54 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	481	13	1,034			1.00
2.00	HMO and other (see instructions)	0	121				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)	481	13	1,034			7.00
8.00	INTENSIVE CARE UNIT	17	0	59			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)	498	13	1,093	0.00	129.35	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	1,101	0	1,815	0.00	12.23	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE			5,026	0.00	14.57	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00	RURAL HEALTH CLINIC						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)				0.00	156.15	27.00
28.00	Observation Bed Days		3	251			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: 14-1335

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/23/2022 7:54 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	158	7	371	1.00
2.00 HMO and other (see instructions)			0	34		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)	1.00	0	158	7	371	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	0.00				0	21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00					25.10
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	1.00					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

Health Financial Systems		HARVARD MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1335	Period: From 07/01/2020 To 06/30/2021	Worksheet S-10 Date/Time Prepared: 2/23/2022 7:54 pm	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.315342	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			2,173,552	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			2,323,575	5.00
6.00	Medicaid charges			11,904,610	6.00
7.00	Medicaid cost (line 1 times line 6)			3,754,024	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)			0	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			10,833	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			0	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	661,451	127,533	788,984	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	208,583	127,533	336,116	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	208,583	127,533	336,116	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			2,844,666	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			274,408	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			422,167	27.01
28.00	Non-Medicare bad debt expense (see instructions)			2,422,499	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			911,675	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			1,247,791	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			1,247,791	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1335

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

Worksheet A

Date/Time Prepared:
2/23/2022 7:54 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	1,098,929	1,098,929	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,903,127	1,903,127	-1,098,929	804,198	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,547,315	1,547,315	0	1,547,315	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	814,525	2,209,898	3,024,423	-307,191	2,717,232	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	916,414	916,414	-332,600	583,814	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	89,492	89,492	0	89,492	8.00
9.00	00900	HOUSEKEEPING	162,835	71,716	234,551	0	234,551	9.00
10.00	01000	DIETARY	408,659	157,314	565,973	0	565,973	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	698,275	65,775	764,050	198,882	962,932	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	158,010	17,500	175,510	0	175,510	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	868,933	142,163	1,011,096	-25,048	986,048	30.00
31.00	03100	INTENSIVE CARE UNIT	223,192	42,598	265,790	-1,111	264,679	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	482,779	482,779	44.00
46.00	04600	OTHER LONG TERM CARE	1,623,798	484,224	2,108,022	-1,194,284	913,738	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	701,350	1,477,577	2,178,927	-953,765	1,225,162	50.00
51.00	05100	RECOVERY ROOM	604,587	130,080	734,667	-33,238	701,429	51.00
53.00	05300	ANESTHESIOLOGY	64,947	1,521,874	1,586,821	0	1,586,821	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	816,393	142,479	958,872	179,529	1,138,401	54.00
60.00	06000	LABORATORY	607,358	194,309	801,667	90,182	891,849	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	91,284	69,796	161,080	-415	160,665	65.00
66.00	06600	PHYSICAL THERAPY	161,924	13,846	175,770	268,777	444,547	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	239,956	239,956	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	35,883	35,883	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	54,822	20,816	75,638	846,198	921,836	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	470,568	470,568	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	181,385	734,150	915,535	62,010	977,545	73.00
76.97	07697	CARDIAC REHABILITATION	17,759	104	17,863	22,756	40,619	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								
91.00	09100	EMERGENCY	925,489	2,025,759	2,951,248	-49,868	2,901,380	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,185,525	13,978,326	23,163,851	0	23,163,851	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	9,185,525	13,978,326	23,163,851	0	23,163,851	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1335

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

Worksheet A

Date/Time Prepared:
2/23/2022 7:54 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	1,098,929	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-5,879	798,319	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	491,873	2,039,188	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,484,410	4,201,642	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	485,863	1,069,677	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	89,492	8.00
9.00	00900	HOUSEKEEPING	0	234,551	9.00
10.00	01000	DIETARY	-75,853	490,120	10.00
11.00	01100	CAFETERIA	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	-106,206	856,726	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	121,032	296,542	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	986,048	30.00
31.00	03100	INTENSIVE CARE UNIT	0	264,679	31.00
44.00	04400	SKILLED NURSING FACILITY	-5,077	477,702	44.00
46.00	04600	OTHER LONG TERM CARE	-52,233	861,505	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-3,337	1,221,825	50.00
51.00	05100	RECOVERY ROOM	0	701,429	51.00
53.00	05300	ANESTHESIOLOGY	-1,459,179	127,642	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-300	1,138,101	54.00
60.00	06000	LABORATORY	0	891,849	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	160,665	65.00
66.00	06600	PHYSICAL THERAPY	0	444,547	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	239,956	67.00
68.00	06800	SPEECH PATHOLOGY	0	35,883	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	58,747	980,583	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	470,568	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	977,545	73.00
76.97	07697	CARDIAC REHABILITATION	0	40,619	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-308,029	2,593,351	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	625,832	23,789,683	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	625,832	23,789,683	200.00

RECLASSIFICATIONS

Provider CCN: 14-1335

Period:
From 07/01/2020
To 06/30/2021Worksheet A-6
Date/Time Prepared:
2/23/2022 7:54 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - SNF/LONG TERM CARE EXP RECLASS				
1.00	SKILLED NURSING FACILITY	44.00	380,948	101,831	1.00
	TOTALS		380,948	101,831	
	B - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	470,568	1.00
	TOTALS		0	470,568	
	C - MANAGER/DIRECTOR RECLASS				
1.00	NURSING ADMINISTRATION	13.00	181,836	17,046	1.00
3.00	OTHER LONG TERM CARE	46.00	78,136	7,417	3.00
4.00	CARDIAC REHABILITATION	76.97	20,942	1,814	4.00
	TOTALS		280,914	26,277	
	D - INTERCOMPANY TRANSACTIONS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	58,293	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	407,731	0	2.00
3.00	OPERATION OF PLANT	7.00	170,136	0	3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00	4,474	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	10,561	0	5.00
6.00	OTHER LONG TERM CARE	46.00	411	0	6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	17,283	7.00
8.00	RESPIRATORY THERAPY	65.00	18,533	0	8.00
9.00	DRUGS CHARGED TO PATIENTS	73.00	111,871	0	9.00
10.00	CARDIAC REHABILITATION	76.97	3,961	0	10.00
11.00	EMERGENCY	91.00	1,896	0	11.00
12.00	OPERATING ROOM	50.00	1,517	0	12.00
	TOTALS		789,384	17,283	
	E - SNF AND LTC RECLASS				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	16,702	4,465	1.00
2.00	LABORATORY	60.00	35,095	9,381	2.00
3.00	RESPIRATORY THERAPY	65.00	566	151	3.00
4.00	PHYSICAL THERAPY	66.00	212,109	56,699	4.00
5.00	OCCUPATIONAL THERAPY	67.00	189,343	50,613	5.00
6.00	SPEECH PATHOLOGY	68.00	28,314	7,569	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	97,877	26,164	7.00
8.00	DRUGS CHARGED TO PATIENTS	73.00	48,930	13,080	8.00
	TOTALS		628,936	168,122	
	F - DEPRECIATION				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,098,929	1.00
15.00		0.00	0	0	15.00
	TOTALS		0	1,098,929	
	G - LOCUM SALARY RECLASS				
1.00	ANESTHESIOLOGY	53.00	1,328,433	0	1.00
2.00	EMERGENCY	91.00	1,513,903	0	2.00
	TOTALS		2,842,336	0	
	H - MEDICAL SUPPLIES CHARGED TO PATIENT				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	722,157	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
	TOTALS		0	722,157	
	I - BIOMEDICAL				
1.00	OPERATING ROOM	50.00	0	63,187	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	223,707	2.00
3.00	LABORATORY	60.00	0	45,706	3.00
	TOTALS		0	332,600	
500.00	Grand Total: Increases		4,922,518	2,937,767	500.00

RECLASSIFICATIONS

Provider CCN: 14-1335

Period:
From 07/01/2020
To 06/30/2021Worksheet A-6
Date/Time Prepared:
2/23/2022 7:54 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - SNF/LONG TERM CARE EXP RECLASS						
1.00	OTHER LONG TERM CARE	46.00	380,948	101,831	0		1.00
	TOTALS		380,948	101,831			
	B - IMPLANTABLE DEVICES						
1.00	OPERATING ROOM	50.00	0	470,568	0		1.00
	TOTALS		0	470,568			
	C - MANAGER/DIRECTOR RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	280,914	26,277	0		1.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		280,914	26,277			
	D - INTERCOMPANY TRANSACTIONS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	58,293	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	407,731	0		2.00
3.00	OPERATION OF PLANT	7.00	0	170,136	0		3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	4,474	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	10,561	0		5.00
6.00	OTHER LONG TERM CARE	46.00	0	411	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	17,283	0	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	18,533	0		8.00
9.00	DRUGS CHARGED TO PATIENTS	73.00	0	111,871	0		9.00
10.00	CARDIAC REHABILITATION	76.97	0	3,961	0		10.00
11.00	EMERGENCY	91.00	0	1,896	0		11.00
12.00	OPERATING ROOM	50.00	0	1,517	0		12.00
	TOTALS		17,283	789,384			
	E - SNF AND LTC RECLASS						
1.00	OTHER LONG TERM CARE	46.00	628,936	168,122	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
	TOTALS		628,936	168,122			
	F - DEPRECIATION						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,098,929	9		1.00
15.00		0.00	0	0	9		15.00
	TOTALS		0	1,098,929			
	G - LOCUM SALARY RECLASS						
1.00	ANESTHESIOLOGY	53.00	0	1,328,433	0		1.00
2.00	EMERGENCY	91.00	0	1,513,903	0		2.00
	TOTALS		0	2,842,336			
	H - MEDICAL SUPPLIES CHARGED TO PATIENT						
1.00	ADULTS & PEDIATRICS	30.00	0	25,048	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	1,111	0		2.00
3.00	OPERATING ROOM	50.00	0	546,384	0		3.00
4.00	RECOVERY ROOM	51.00	0	33,238	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	65,345	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	1,132	0		6.00
7.00	PHYSICAL THERAPY	66.00	0	31	0		7.00
8.00	EMERGENCY	91.00	0	49,868	0		8.00
	TOTALS		0	722,157			
	I - BIOMEDICAL						
1.00	OPERATION OF PLANT	7.00	0	332,600	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	332,600			
500.00	Grand Total: Decreases		1,308,081	6,552,204			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1335

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part I
Date/Time Prepared:
2/23/2022 7:54 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	222,604	0	0	0	0	1.00	
2.00	Land Improvements	852,309	30,776	0	30,776	0	2.00	
3.00	Buildings and Fixtures	0	0	0	0	0	3.00	
4.00	Building Improvements	22,066,464	164,802	0	164,802	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	17,827,134	804,282	0	804,282	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	40,968,511	999,860	0	999,860	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	40,968,511	999,860	0	999,860	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	222,604	0				1.00	
2.00	Land Improvements	883,085	0				2.00	
3.00	Buildings and Fixtures	0	0				3.00	
4.00	Building Improvements	22,231,266	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	18,631,416	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	41,968,371	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	41,968,371	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1335

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part II
Date/Time Prepared:
2/23/2022 7:54 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,624,524	0	278,603	0	0	2.00
3.00	Total (sum of lines 1-2)	1,624,524	0	278,603	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		1,903,127				2.00
3.00	Total (sum of lines 1-2)	0	1,903,127				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1335

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part III
Date/Time Prepared:
2/23/2022 7:54 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	23,336,955	0	23,336,955	0.556061	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	18,631,416	0	18,631,416	0.443939	0	2.00
3.00	Total (sum of lines 1-2)	41,968,371	0	41,968,371	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,098,929	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	525,595	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,624,524	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,098,929	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	272,724	0	0	0	798,319	2.00
3.00	Total (sum of lines 1-2)	272,724	0	0	0	1,897,248	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1335

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

Worksheet A-8

Date/Time Prepared:
2/23/2022 7:54 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	A	-5,879	CAP REL COSTS-MVBLE EQUIP	2.00	11	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)	A	-4,009	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,996,646			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	3,564,782			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-75,853	DIETARY	10.00	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	B	-40	MEDICAL RECORDS & LIBRARY	16.00	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	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER OPERATING REVENUE	B	-118	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1335

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

Worksheet A-8

Date/Time Prepared:
2/23/2022 7:54 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
34.00	ILLINOIS UNALLOWABLE REAL ESTAT	A	-8,484	OPERATION OF PLANT	7.00	0	34.00
35.00	LOBBYING EXPENSE	A	-10,964	ADMINISTRATIVE & GENERAL	5.00	0	35.00
37.00	HOSPITAL TAX	A	-775,962	ADMINISTRATIVE & GENERAL	5.00	0	37.00
39.00	CASH DISCOUNTS	B	-95	ADMINISTRATIVE & GENERAL	5.00	0	39.00
42.00	SNF TAX	A	-6,537	SKILLED NURSING FACILITY	44.00	0	42.00
43.00	CARE CENTER TAX	A	-54,363	OTHER LONG TERM CARE	46.00	0	43.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		625,832				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: 14-1335

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

Worksheet A-8-1

Date/Time Prepared:
2/23/2022 7:54 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5		
	1.00	2.00	3.00	4.00	5.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00		4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE EMPLOYEE BENEFIT	560,280	68,407	1.00
2.00		5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ADMIN & GENERAL	3,160,121	980,776	2.00
3.00		7.00	OPERATION OF PLANT	HOME OFFICE OPERATION OF PLA	498,356	0	3.00
3.01		71.00	MEDICAL SUPPLIES CHARGED TO	HOME OFFICE MEDICAL SUPPLIES	58,747	0	3.01
3.02		16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE MEDICAL RECORDS	121,072	0	3.02
3.07		5.00	ADMINISTRATIVE & GENERAL	MED DIRECTOR DIRECT ALLOC	68,871	0	3.07
3.09		0.00			0	0	3.09
3.10		91.00	EMERGENCY	MED DIRECTOR DIRECT ALLOC	33,333	0	3.10
3.11		44.00	SKILLED NURSING FACILITY	MED DIRECTOR DIRECT ALLOC	1,460	0	3.11
3.12		46.00	OTHER LONG TERM CARE	MED DIRECTOR DIRECT ALLOC	2,130	0	3.12
3.14		5.00	ADMINISTRATIVE & GENERAL	MED DIRECTOR DIRECT ALLOC	23,333	0	3.14
3.16		53.00	ANESTHESIOLOGY	PHYSICIAN BENEFITS	33,214	0	3.16
3.17		91.00	EMERGENCY	PHYSICIAN BENEFITS	53,048	0	3.17
4.00		0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				4,613,965	1,049,183	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		
Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
1.00	2.00	3.00	4.00	5.00	

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	B	0.00	MERCY HOME OFFI	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: 14-1335

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

Worksheet A-8-1

Date/Time Prepared:
2/23/2022 7:54 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	491,873	0		1.00
2.00	2,179,345	0		2.00
3.00	498,356	0		3.00
3.01	58,747	0		3.01
3.02	121,072	0		3.02
3.07	68,871	0		3.07
3.09	0	0		3.09
3.10	33,333	0		3.10
3.11	1,460	0		3.11
3.12	2,130	0		3.12
3.14	23,333	9		3.14
3.16	33,214	0		3.16
3.17	53,048	0		3.17
4.00	0	0		4.00
5.00	3,564,782			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	HEALTH SYSTEM		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: 14-1335

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

Worksheet A-8-2

Date/Time Prepared:
2/23/2022 7:54 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	13.00	AGGREGATE-NURSING ADMINISTRATION	106,206	106,206	0	0	0	1.00
2.00	50.00	AGGREGATE-OPERATING ROOM	46,849	3,337	43,512	0	0	2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	1,492,393	1,492,393	0	0	0	3.00
4.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	300	300	0	0	0	4.00
5.00	91.00	AGGREGATE-EMERGENCY	1,809,220	394,410	1,414,810	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			3,454,968	1,996,646	1,458,322			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	13.00	AGGREGATE-NURSING ADMINISTRATION	0	0	0	0	0	1.00
2.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	91.00	AGGREGATE-EMERGENCY	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	13.00	AGGREGATE-NURSING ADMINISTRATION	0	0	0	106,206		1.00
2.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	3,337		2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	1,492,393		3.00
4.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	300		4.00
5.00	91.00	AGGREGATE-EMERGENCY	0	0	0	394,410		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	1,996,646		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1335

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
2/23/2022 7:54 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,098,929	1,098,929			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	798,319		798,319		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,039,188	0	0	2,039,188	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,201,642	131,767	7,762	364,543	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,069,677	218,562	77,457	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	89,492	12,684	1,230	0	8.00
9.00	00900	HOUSEKEEPING	234,551	4,997	389	28,479	9.00
10.00	01000	DIETARY	490,120	33,810	16,591	71,472	10.00
11.00	01100	CAFETERIA	0	18,175	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	856,726	6,095	56,301	138,465	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	296,542	23,405	0	27,635	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	986,048	91,615	45,598	151,970	30.00
31.00	03100	INTENSIVE CARE UNIT	264,679	25,231	1,069	39,035	31.00
44.00	04400	SKILLED NURSING FACILITY	477,702	65,520	6,118	66,625	44.00
46.00	04600	OTHER LONG TERM CARE	861,505	112,549	8,924	121,035	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,221,825	109,900	266,745	115,173	50.00
51.00	05100	RECOVERY ROOM	701,429	4,393	8,776	105,738	51.00
53.00	05300	ANESTHESIOLOGY	127,642	0	413	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,138,101	29,033	224,998	145,702	54.00
60.00	06000	LABORATORY	891,849	20,961	7,787	112,361	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	160,665	17,708	13,134	16,064	65.00
66.00	06600	PHYSICAL THERAPY	444,547	49,569	5,235	65,416	66.00
67.00	06700	OCCUPATIONAL THERAPY	239,956	0	3,041	33,115	67.00
68.00	06800	SPEECH PATHOLOGY	35,883	0	455	4,952	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	980,583	0	6,513	26,706	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	470,568	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	977,545	7,413	992	40,280	73.00
76.97	07697	CARDIAC REHABILITATION	40,619	6,864	13,787	6,769	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							
91.00	09100	EMERGENCY	2,593,351	19,946	25,004	357,653	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,789,683	1,010,197	798,319	2,039,188	23,700,951
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	88,732	0	0	192.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	23,789,683	1,098,929	798,319	2,039,188	23,789,683

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,705,714					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	336,752	0	1,702,448			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	25,498	0	28,846	157,750		8.00
9.00	00900	HOUSEKEEPING	66,186	0	11,363	22,915	368,880	9.00
10.00	01000	DIETARY	150,905	0	76,890	0	17,063	10.00
11.00	01100	CAFETERIA	4,482	0	41,333	0	9,172	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	260,779	0	13,861	0	3,076	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	85,706	0	53,227	0	11,812	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	314,445	0	208,350	20,741	46,236	30.00
31.00	03100	INTENSIVE CARE UNIT	81,375	0	57,379	48	12,733	31.00
44.00	04400	SKILLED NURSING FACILITY	151,884	0	149,004	12,445	33,067	44.00
46.00	04600	OTHER LONG TERM CARE	272,226	0	255,956	15,228	56,803	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	422,548	0	249,932	29,821	55,464	50.00
51.00	05100	RECOVERY ROOM	202,278	0	9,990	7,456	2,217	51.00
53.00	05300	ANESTHESIOLOGY	31,576	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	379,198	0	66,026	8,540	14,652	54.00
60.00	06000	LABORATORY	254,706	0	47,670	1,162	10,579	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	51,183	0	40,271	7,829	8,937	65.00
66.00	06600	PHYSICAL THERAPY	139,260	0	112,729	6,084	25,016	66.00
67.00	06700	OCCUPATIONAL THERAPY	68,083	0	0	5,362	0	67.00
68.00	06800	SPEECH PATHOLOGY	10,181	0	0	970	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	249,982	0	0	1,056	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	116,032	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	253,047	0	16,858	3,139	3,741	73.00
76.97	07697	CARDIAC REHABILITATION	16,777	0	15,609	68	3,464	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								
91.00	09100	EMERGENCY	738,746	0	45,360	14,886	10,066	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,683,835	0	1,500,654	157,750	324,098	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	21,879	0	201,794	0	44,782	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,705,714	0	1,702,448	157,750	368,880	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	856,851					10.00
11.00	01100	CAFETERIA	216,784	289,946				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	19,050	0	1,354,353		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,040	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	79,634	26,654	0	266,934	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	6,153	0	39,620	0	31.00
44.00	04400	SKILLED NURSING FACILITY	224,983	17,519	0	61,977	0	44.00
46.00	04600	OTHER LONG TERM CARE	328,208	25,553	0	192,712	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	23,349	0	175,470	0	50.00
51.00	05100	RECOVERY ROOM	0	20,447	0	196,374	0	51.00
53.00	05300	ANESTHESIOLOGY	0	11,312	0	15,092	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	23,484	0	22,939	0	54.00
60.00	06000	LABORATORY	0	25,257	0	19,665	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	4,514	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	15,853	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,706	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,290	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,523	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,598	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,585	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								
91.00	09100	EMERGENCY	7,242	36,059	0	363,570	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	856,851	289,946	0	1,354,353	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	856,851	289,946	0	1,354,353	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
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	0					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	505,367				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		0		19.00
20.00	02000	NURSING PROGRAM	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	39,940	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,668	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	305,259	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	91,292	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	9,781	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
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								
91.00	09100	EMERGENCY	0	55,427	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	505,367	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	505,367	0	0	0	202.00

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00				
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING PROGRAM						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	2,278,165	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	530,990	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	1,266,844	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	2,250,699	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	2,975,486	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,259,098	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	186,035	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,143,965	0	54.00
60.00	06000	LABORATORY	0	0	0	1,391,997	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	320,305	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	873,490	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	358,263	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	53,731	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,272,363	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	586,600	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,311,613	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	105,542	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								
91.00	09100	EMERGENCY	0	0	0	4,267,310	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	23,432,496	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	357,187	0	192.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	23,789,683	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1335

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING PROGRAM	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
44.00	04400	SKILLED NURSING FACILITY	44.00
46.00	04600	OTHER LONG TERM CARE	46.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
60.01	06001	BLOOD LABORATORY	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	99.10
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1335

Period:
From 07/01/2020
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
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	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	32,808	131,767	7,762	172,337	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	42,532	218,562	77,457	338,551	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	853	12,684	1,230	14,767	8.00
9.00	00900	HOUSEKEEPING	886	4,997	389	6,272	9.00
10.00	01000	DIETARY	975	33,810	16,591	51,376	10.00
11.00	01100	CAFETERIA	0	18,175	0	18,175	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	121	6,095	56,301	62,517	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	23,405	0	23,405	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,570	91,615	45,598	141,783	30.00
31.00	03100	INTENSIVE CARE UNIT	0	25,231	1,069	26,300	31.00
44.00	04400	SKILLED NURSING FACILITY	3,158	65,520	6,118	74,796	44.00
46.00	04600	OTHER LONG TERM CARE	4,608	112,549	8,924	126,081	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	15,940	109,900	266,745	392,585	50.00
51.00	05100	RECOVERY ROOM	1,393	4,393	8,776	14,562	51.00
53.00	05300	ANESTHESIOLOGY	0	0	413	413	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	557	29,033	224,998	254,588	54.00
60.00	06000	LABORATORY	12,856	20,961	7,787	41,604	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,075	17,708	13,134	32,917	65.00
66.00	06600	PHYSICAL THERAPY	1,809	49,569	5,235	56,613	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,570	0	3,041	4,611	67.00
68.00	06800	SPEECH PATHOLOGY	235	0	455	690	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	811	0	6,513	7,324	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	59,817	7,413	992	68,222	73.00
76.97	07697	CARDIAC REHABILITATION	0	6,864	13,787	20,651	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							
91.00	09100	EMERGENCY	408	19,946	25,004	45,358	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	187,982	1,010,197	798,319	1,996,498	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	88,732	0	88,732	192.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	187,982	1,098,929	798,319	2,085,230	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1335

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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	172,337					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	12,332	0	350,883			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	934	0	5,945	21,646		8.00
9.00	00900	HOUSEKEEPING	2,424	0	2,342	3,144	14,182	9.00
10.00	01000	DIETARY	5,526	0	15,847	0	656	10.00
11.00	01100	CAFETERIA	164	0	8,519	0	353	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	9,550	0	2,857	0	118	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,139	0	10,970	0	454	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,515	0	42,942	2,846	1,778	30.00
31.00	03100	INTENSIVE CARE UNIT	2,980	0	11,826	7	490	31.00
44.00	04400	SKILLED NURSING FACILITY	5,562	0	30,710	1,708	1,271	44.00
46.00	04600	OTHER LONG TERM CARE	9,969	0	52,756	2,090	2,183	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	15,474	0	51,512	4,091	2,132	50.00
51.00	05100	RECOVERY ROOM	7,408	0	2,059	1,023	85	51.00
53.00	05300	ANESTHESIOLOGY	1,156	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,887	0	13,608	1,172	563	54.00
60.00	06000	LABORATORY	9,328	0	9,825	159	407	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,874	0	8,300	1,074	344	65.00
66.00	06600	PHYSICAL THERAPY	5,100	0	23,234	835	962	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,493	0	0	736	0	67.00
68.00	06800	SPEECH PATHOLOGY	373	0	0	133	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,155	0	0	145	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,249	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,267	0	3,474	431	144	73.00
76.97	07697	CARDIAC REHABILITATION	614	0	3,217	9	133	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								
91.00	09100	EMERGENCY	27,063	0	9,349	2,043	387	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	171,536	0	309,292	21,646	12,460	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	801	0	41,591	0	1,722	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	172,337	0	350,883	21,646	14,182	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1335

Period:
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To 06/30/2021Worksheet B
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	73,405					10.00
11.00	01100	CAFETERIA	18,572	45,783				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	3,008	0	78,050		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,112	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,822	4,209	0	15,383	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	972	0	2,283	0	31.00
44.00	04400	SKILLED NURSING FACILITY	19,274	2,766	0	3,572	0	44.00
46.00	04600	OTHER LONG TERM CARE	28,117	4,035	0	11,106	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	3,687	0	10,112	0	50.00
51.00	05100	RECOVERY ROOM	0	3,229	0	11,317	0	51.00
53.00	05300	ANESTHESIOLOGY	0	1,786	0	870	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,708	0	1,322	0	54.00
60.00	06000	LABORATORY	0	3,988	0	1,133	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	713	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,503	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,375	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	204	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,188	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,358	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	250	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								
91.00	09100	EMERGENCY	620	5,692	0	20,952	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	73,405	45,783	0	78,050	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	73,405	45,783	0	78,050	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1335

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
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	0					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	39,080				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		0		19.00
20.00	02000	NURSING PROGRAM	0	0		0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0		0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	3,089		0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	284		0		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0		0		44.00
46.00	04600	OTHER LONG TERM CARE	0	0		0		46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	23,605		0		50.00
51.00	05100	RECOVERY ROOM	0	0		0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,060		0		54.00
60.00	06000	LABORATORY	0	0		0		60.00
60.01	06001	BLOOD LABORATORY	0	0		0		60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		0		65.00
66.00	06600	PHYSICAL THERAPY	0	756		0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		0		73.00
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								
91.00	09100	EMERGENCY	0	4,286		0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0		0		99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	39,080		0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		0		192.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0		0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	39,080		0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1335

Period:
From 07/01/2020
To 06/30/2021Worksheet B
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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING PROGRAM						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				230,367	0	30.00
31.00	03100	INTENSIVE CARE UNIT				45,142	0	31.00
44.00	04400	SKILLED NURSING FACILITY				139,659	0	44.00
46.00	04600	OTHER LONG TERM CARE				236,337	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM				503,198	0	50.00
51.00	05100	RECOVERY ROOM				39,683	0	51.00
53.00	05300	ANESTHESIOLOGY				4,225	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				295,908	0	54.00
60.00	06000	LABORATORY				66,444	0	60.00
60.01	06001	BLOOD LABORATORY				0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
65.00	06500	RESPIRATORY THERAPY				45,222	0	65.00
66.00	06600	PHYSICAL THERAPY				90,003	0	66.00
67.00	06700	OCCUPATIONAL THERAPY				9,215	0	67.00
68.00	06800	SPEECH PATHOLOGY				1,400	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				17,812	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				4,249	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				82,896	0	73.00
76.97	07697	CARDIAC REHABILITATION				24,874	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								
91.00	09100	EMERGENCY				115,750	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF				0	0	99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	1,952,384	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES				132,846	0	192.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	2,085,230	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1335

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING PROGRAM	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
44.00	04400	SKILLED NURSING FACILITY	44.00
46.00	04600	OTHER LONG TERM CARE	46.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
60.01	06001	BLOOD LABORATORY	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	99.10
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1335

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	80,055					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		773,801				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	11,659,636			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,599	7,524	2,084,393	-4,705,714	19,083,969	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	15,922	75,078	0	0	1,365,696	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	924	1,192	0	0	103,406	8.00
9.00	00900	HOUSEKEEPING	364	377	162,835	0	268,416	9.00
10.00	01000	DIETARY	2,463	16,081	408,659	0	611,993	10.00
11.00	01100	CAFETERIA	1,324	0	0	0	18,175	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	444	54,572	791,710	0	1,057,587	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,705	0	158,010	0	347,582	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,674	44,198	868,933	0	1,275,231	30.00
31.00	03100	INTENSIVE CARE UNIT	1,838	1,036	223,192	0	330,014	31.00
44.00	04400	SKILLED NURSING FACILITY	4,773	5,930	380,948	0	615,965	44.00
46.00	04600	OTHER LONG TERM CARE	8,199	8,650	692,050	0	1,104,013	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,006	258,552	658,534	0	1,713,643	50.00
51.00	05100	RECOVERY ROOM	320	8,506	604,587	0	820,336	51.00
53.00	05300	ANESTHESIOLOGY	0	400	0	0	128,055	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,115	218,088	833,095	0	1,537,834	54.00
60.00	06000	LABORATORY	1,527	7,548	642,453	0	1,032,958	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,290	12,731	91,850	0	207,571	65.00
66.00	06600	PHYSICAL THERAPY	3,611	5,074	374,033	0	564,767	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,948	189,343	0	276,112	67.00
68.00	06800	SPEECH PATHOLOGY	0	441	28,314	0	41,290	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,313	152,699	0	1,013,802	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	470,568	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	540	962	230,315	0	1,026,230	73.00
76.97	07697	CARDIAC REHABILITATION	500	13,364	38,701	0	68,039	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								
91.00	09100	EMERGENCY	1,453	24,236	2,044,982	0	2,995,954	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	73,591	773,801	11,659,636	-4,705,714	18,995,237	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,464	0	0	0	88,732	192.00
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)	1,098,929	798,319	2,039,188		4,705,714	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.727175	1.031685	0.174893		0.246579	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		172,337	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.009030	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: 14-1335

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
7.00	00700	OPERATION OF PLANT	0	54,534			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	924	151,285		8.00
9.00	00900	HOUSEKEEPING	0	364	21,976	53,246	9.00
10.00	01000	DIETARY	0	2,463	0	2,463	34,905 10.00
11.00	01100	CAFETERIA	0	1,324	0	1,324	8,831 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	0	444	0	444	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0 14.00
15.00	01500	PHARMACY	0	0	0	0	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,705	0	1,705	0 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0 20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0 22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	6,674	19,891	6,674	3,244 30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,838	46	1,838	0 31.00
44.00	04400	SKILLED NURSING FACILITY	0	4,773	11,935	4,773	9,165 44.00
46.00	04600	OTHER LONG TERM CARE	0	8,199	14,604	8,199	13,370 46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	8,006	28,600	8,006	0 50.00
51.00	05100	RECOVERY ROOM	0	320	7,150	320	0 51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,115	8,190	2,115	0 54.00
60.00	06000	LABORATORY	0	1,527	1,114	1,527	0 60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0 60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0	1,290	7,508	1,290	0 65.00
66.00	06600	PHYSICAL THERAPY	0	3,611	5,835	3,611	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	5,142	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	930	0	0 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,013	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	540	3,010	540	0 73.00
76.97	07697	CARDIAC REHABILITATION	0	500	65	500	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							
91.00	09100	EMERGENCY	0	1,453	14,276	1,453	295 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0 99.10
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	48,070	151,285	46,782	34,905 118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,464	0	6,464	0 192.00
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	1,702,448	157,750	368,880	856,851 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	31.218102	1.042734	6.927844	24.548088 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	350,883	21,646	14,182	73,405 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	6.434206	0.143081	0.266349	2.102994 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: 14-1335

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAFETERIA (FULL TIME EQUIVALE)	MAINTENANCE OF PERSONNEL (FULL TIME EQUIVALE)	NURSING ADMINISTRATION (DIRECT NRS ING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	10,791					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	709	0	69,906			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0		14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	262	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	992	0	13,778	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	229	0	2,045	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	652	0	3,199	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	951	0	9,947	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	869	0	9,057	0	0	50.00
51.00	05100	RECOVERY ROOM	761	0	10,136	0	0	51.00
53.00	05300	ANESTHESIOLOGY	421	0	779	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	874	0	1,184	0	0	54.00
60.00	06000	LABORATORY	940	0	1,015	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	168	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	590	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	324	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	48	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	280	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	320	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	59	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								
91.00	09100	EMERGENCY	1,342	0	18,766	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,791	0	69,906	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	289,946	0	1,354,353	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	26.869243	0.000000	19.373916	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	45,783	0	78,050	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.242702	0.000000	1.116499	0.000000	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: 14-1335

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

Worksheet B-1

Date/Time Prepared:
2/23/2022 7:54 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING PROGRAM (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
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	1,240					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING PROGRAM	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	98	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	9	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	749	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	224	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	24	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
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								
91.00	09100	EMERGENCY	136	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,240	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	505,367	0	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	407.554032	0.000000	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	39,080	0	0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	31.516129	0.000000	0.000000	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1335

Period:
From 07/01/2020
To 06/30/2021Worksheet B-1
Date/Time Prepared:
2/23/2022 7:54 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHER		
			PRGM COSTS APPRV (ASSIGNED TIME)		
			22.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING PROGRAM			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
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					
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
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	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1335

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
2/23/2022 7:54 pm

			Title XVIII		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	2,278,165		2,278,165	0	2,278,165	30.00
31.00	03100	INTENSIVE CARE UNIT	530,990		530,990	0	530,990	31.00
44.00	04400	SKILLED NURSING FACILITY	1,266,844		1,266,844	0	1,266,844	44.00
46.00	04600	OTHER LONG TERM CARE	2,250,699		2,250,699	0	2,250,699	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,975,486		2,975,486	0	2,975,486	50.00
51.00	05100	RECOVERY ROOM	1,259,098		1,259,098	0	1,259,098	51.00
53.00	05300	ANESTHESIOLOGY	186,035		186,035	0	186,035	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,143,965		2,143,965	0	2,143,965	54.00
60.00	06000	LABORATORY	1,391,997		1,391,997	0	1,391,997	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	320,305	0	320,305	0	320,305	65.00
66.00	06600	PHYSICAL THERAPY	873,490	0	873,490	0	873,490	66.00
67.00	06700	OCCUPATIONAL THERAPY	358,263	0	358,263	0	358,263	67.00
68.00	06800	SPEECH PATHOLOGY	53,731	0	53,731	0	53,731	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,272,363		1,272,363	0	1,272,363	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	586,600		586,600	0	586,600	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,311,613		1,311,613	0	1,311,613	73.00
76.97	07697	CARDIAC REHABILITATION	105,542		105,542	0	105,542	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								
91.00	09100	EMERGENCY	4,267,310		4,267,310	0	4,267,310	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	444,995		444,995		444,995	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0		0		0	99.10
200.00		Subtotal (see instructions)	23,877,491	0	23,877,491	0	23,877,491	200.00
201.00		Less Observation Beds	444,995		444,995		444,995	201.00
202.00		Total (see instructions)	23,432,496	0	23,432,496	0	23,432,496	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1335

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
2/23/2022 7:54 pm

			Title XVIII		Hospital	Cost		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,524,066		3,524,066			30.00
31.00	03100	INTENSIVE CARE UNIT	436,048		436,048			31.00
44.00	04400	SKILLED NURSING FACILITY	760,232		760,232			44.00
46.00	04600	OTHER LONG TERM CARE	892,447		892,447			46.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,771,779	18,079,810	21,851,589	0.136168	0.000000	50.00
51.00	05100	RECOVERY ROOM	147,136	3,397,025	3,544,161	0.355260	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	75,656	75,656	2.458959	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,071,267	13,095,073	14,166,340	0.151342	0.000000	54.00
60.00	06000	LABORATORY	569,846	3,315,276	3,885,122	0.358289	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	36,124	336,070	372,194	0.860586	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	635,842	944,948	1,580,790	0.552565	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	334,179	0	334,179	1.072069	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	49,972	0	49,972	1.075222	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,694,216	5,320,003	7,014,219	0.181398	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,241,606	959,110	2,200,716	0.266550	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,671,603	4,827,034	6,498,637	0.201829	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	138,547	138,547	0.761778	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							
91.00	09100	EMERGENCY	330,262	5,928,924	6,259,186	0.681768	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	38,930	685,065	723,995	0.614638	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0			99.10
200.00		Subtotal (see instructions)	17,205,555	57,102,541	74,308,096			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	17,205,555	57,102,541	74,308,096			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1335

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
2/23/2022 7:54 pm

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
44.00	04400	SKILLED NURSING FACILITY				44.00
46.00	04600	OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.136168			50.00
51.00	05100	RECOVERY ROOM	0.355260			51.00
53.00	05300	ANESTHESIOLOGY	2.458959			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151342			54.00
60.00	06000	LABORATORY	0.358289			60.00
60.01	06001	BLOOD LABORATORY	0.000000			60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.860586			65.00
66.00	06600	PHYSICAL THERAPY	0.552565			66.00
67.00	06700	OCCUPATIONAL THERAPY	1.072069			67.00
68.00	06800	SPEECH PATHOLOGY	1.075222			68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.181398			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.266550			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.201829			73.00
76.97	07697	CARDIAC REHABILITATION	0.761778			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.681768			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.614638			92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

Worksheet C
Part I
Date/Time Prepared:
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COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1335

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
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				Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0		0			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00
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							
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0			99.10
200.00		Subtotal (see instructions)	0	0	0			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	0	0	0			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1335

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
2/23/2022 7:54 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
44.00	04400	SKILLED NURSING FACILITY				44.00
46.00	04600	OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000	LABORATORY	0.000000			60.00
60.01	06001	BLOOD LABORATORY	0.000000			60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
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
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						
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1335

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part II
Date/Time Prepared:
2/23/2022 7:54 pm

Cost Center Description			Title XVIII		Hospital	Cost	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	503,198	21,851,589	0.023028	1,187,337	27,342
51.00	05100	RECOVERY ROOM	39,683	3,544,161	0.011197	40,277	451
53.00	05300	ANESTHESIOLOGY	4,225	75,656	0.055845	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	295,908	14,166,340	0.020888	291,211	6,083
60.00	06000	LABORATORY	66,444	3,885,122	0.017102	332,726	5,690
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0
65.00	06500	RESPIRATORY THERAPY	45,222	372,194	0.121501	14,178	1,723
66.00	06600	PHYSICAL THERAPY	90,003	1,580,790	0.056935	149,907	8,535
67.00	06700	OCCUPATIONAL THERAPY	9,215	334,179	0.027575	0	0
68.00	06800	SPEECH PATHOLOGY	1,400	49,972	0.028016	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,812	7,014,219	0.002539	574,893	1,460
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,249	2,200,716	0.001931	493,368	953
73.00	07300	DRUGS CHARGED TO PATIENTS	82,896	6,498,637	0.012756	576,274	7,351
76.97	07697	CARDIAC REHABILITATION	24,874	138,547	0.179535	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	115,750	6,259,186	0.018493	3,093	57
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	44,998	723,995	0.062152	3,477	216
200.00		Total (lines 50 through 199)	1,345,877	68,695,303		3,666,741	59,861

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1335

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description			Title XVIII		Hospital		Cost
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health
			1.00	2A	2.00	3A	3.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0 51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0 60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
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							
91.00	09100	EMERGENCY	0	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0 92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1335		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 2/23/2022 7:54 pm	
			Title XVIII		Hospital		Cost	
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	21,851,589	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,544,161	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	75,656	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,166,340	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	3,885,122	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	372,194	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,580,790	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	334,179	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	49,972	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	7,014,219	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,200,716	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,498,637	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	138,547	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								
91.00	09100	EMERGENCY	0	0	0	6,259,186	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	723,995	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	68,695,303		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1335

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

Worksheet D
Part IV
Date/Time Prepared:
2/23/2022 7:54 pm

				Title XVIII		Hospital	Cost	
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	1,187,337	0	0	0
51.00	05100	RECOVERY ROOM		0.000000	40,277	0	0	0
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	291,211	0	0	0
60.00	06000	LABORATORY		0.000000	332,726	0	0	0
60.01	06001	BLOOD LABORATORY		0.000000	0	0	0	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0.000000	0	0	0	0
65.00	06500	RESPIRATORY THERAPY		0.000000	14,178	0	0	0
66.00	06600	PHYSICAL THERAPY		0.000000	149,907	0	0	0
67.00	06700	OCCUPATIONAL THERAPY		0.000000	0	0	0	0
68.00	06800	SPEECH PATHOLOGY		0.000000	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	574,893	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	493,368	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	576,274	0	0	0
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY		0.000000	0	0	0	0
76.99	07699	LITHOTRIPSY		0.000000	0	0	0	0
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY		0.000000	3,093	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	3,477	0	0	0
200.00		Total (lines 50 through 199)			3,666,741	0	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1335

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
2/23/2022 7:54 pm

				Title XVIII		Hospital		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.136168	0	4,450,858	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.355260	0	913,897	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	2.458959	0	51,593	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151342	0	4,109,758	0	0	0	54.00
60.00	06000	LABORATORY	0.358289	0	1,722,719	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.860586	0	68,466	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.552565	0	216,675	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.072069	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.075222	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.181398	0	1,421,987	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.266550	0	312,013	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.201829	0	1,777,568	165,966	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.761778	0	89,231	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.681768	0	1,563,444	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.614638	0	224,102	0	0	0	92.00
200.00		Subtotal (see instructions)		0	16,922,311	165,966	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0			201.00
202.00		Net Charges (line 200 - line 201)		0	16,922,311	165,966	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1335

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
2/23/2022 7:54 pm

				Title XVIII	Hospital	Cost
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	606,064	0		50.00
51.00	05100	RECOVERY ROOM	324,671	0		51.00
53.00	05300	ANESTHESIOLOGY	126,865	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	621,979	0		54.00
60.00	06000	LABORATORY	617,231	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	58,921	0		65.00
66.00	06600	PHYSICAL THERAPY	119,727	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	257,946	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	83,167	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	358,765	33,497		73.00
76.97	07697	CARDIAC REHABILITATION	67,974	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					
91.00	09100	EMERGENCY	1,065,906	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	137,742	0		92.00
200.00		Subtotal (see instructions)	4,446,958	33,497		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	4,446,958	33,497		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1335

Period:

Worksheet D

Component CCN: 14-6014

From 07/01/2020
To 06/30/2021Part V
Date/Time Prepared:
2/23/2022 7:54 pm

Title XVIII

Skilled Nursing
Facility

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	0.136168	0	0	0	0 50.00
51.00	05100 RECOVERY ROOM	0.355260	0	0	0	0 51.00
53.00	05300 ANESTHESIOLOGY	2.458959	0	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.151342	0	0	0	0 54.00
60.00	06000 LABORATORY	0.358289	0	0	0	0 60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0 60.01
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0 62.30
65.00	06500 RESPIRATORY THERAPY	0.860586	0	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.552565	0	0	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	1.072069	0	0	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	1.075222	0	0	0	0 68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.181398	0	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.266550	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.201829	0	0	7,771	0 73.00
76.97	07697 CARDIAC REHABILITATION	0.761778	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						
91.00	09100 EMERGENCY	0.681768	0	0	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.614638	0	0	0	0 92.00
200.00	Subtotal (see instructions)		0	0	7,771	0 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 - line 201)		0	0	7,771	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1335

Period:

Worksheet D

Component CCN: 14-6014

From 07/01/2020
To 06/30/2021Part V
Date/Time Prepared:
2/23/2022 7:54 pm

Title XVIII

Skilled Nursing
Facility

PPS

Cost Center Description			Costs		
			Cost	Cost	
			Reimbursed	Reimbursed	
			Services	Services Not	
			Subject To	Subject To	
			Ded. & Coins.	Ded. & Coins.	
			(see inst.)	(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
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
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	1,568	73.00
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					
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	1,568	200.00
201.00		Less PBP Clinic Lab. Services-Program	0		201.00
		Only Charges			
202.00		Net Charges (line 200 - line 201)	0	1,568	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-1335

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part I
Date/Time Prepared:
2/23/2022 7:54 pm

			Title XIX		Hospital	Cost	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	230,367	0	230,367	1,285	179.27	30.00
31.00	INTENSIVE CARE UNIT	45,142		45,142	59	765.12	31.00
44.00	SKILLED NURSING FACILITY	139,659		139,659	1,815	76.95	44.00
200.00	Total (lines 30 through 199)	415,168		415,168	3,159		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	13	2,331				30.00
31.00	INTENSIVE CARE UNIT	0	0				31.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
200.00	Total (lines 30 through 199)	13	2,331				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1335

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part II
Date/Time Prepared:
2/23/2022 7:54 pm

Cost Center Description			Title XIX		Hospital		Cost	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	503,198	0	0.000000	0	0	50.00
51.00	05100	RECOVERY ROOM	39,683	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	4,225	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	295,908	0	0.000000	0	0	54.00
60.00	06000	LABORATORY	66,444	0	0.000000	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	45,222	0	0.000000	0	0	65.00
66.00	06600	PHYSICAL THERAPY	90,003	0	0.000000	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,215	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,400	0	0.000000	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,812	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,249	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	82,896	0	0.000000	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	24,874	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								
91.00	09100	EMERGENCY	115,750	0	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	44,998	0	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	1,345,877	0		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-1335		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part III Date/Time Prepared: 2/23/2022 7:54 pm	
					Title XIX		Hospital		Cost	
Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
		INPATIENT ROUTINE SERVICE COST CENTERS	1A	1.00	2A	2.00	3.00			
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00		
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00		
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days			
		INPATIENT ROUTINE SERVICE COST CENTERS	4.00	5.00	6.00	7.00	8.00			
30.00	03000	ADULTS & PEDIATRICS	0	0	1,285	0.00	13	30.00		
31.00	03100	INTENSIVE CARE UNIT		0	59	0.00	0	31.00		
44.00	04400	SKILLED NURSING FACILITY		0	1,815	0.00	0	44.00		
200.00		Total (lines 30 through 199)		0	3,159		13	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
44.00	04400	SKILLED NURSING FACILITY	0							44.00
200.00		Total (lines 30 through 199)	0							200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1335

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/23/2022 7:54 pm

Cost Center Description			Title XIX		Hospital		Cost
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health
			1.00	2A	2.00	3A	3.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0 51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0 60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
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							
91.00	09100	EMERGENCY	0	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0 92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1335

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/23/2022 7:54 pm

Cost Center Description		Title XIX		Hospital		Cost	
		All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
		4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1335

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/23/2022 7:54 pm

Cost Center Description			Title XIX		Hospital		Cost	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
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								
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

Health Financial Systems		HARVARD MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1335	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 2/23/2022 7:54 pm	
		Title XVIII	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)			1,285	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,285	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			1,034	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)			481	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				17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				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)			2,278,165	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)			2,278,165	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)			2,278,165	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)			1,772.89	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			852,760	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)			852,760	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1335

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

Worksheet D-1

Date/Time Prepared:
2/23/2022 7:54 pm

Cost Center Description		Title XVIII		Hospital		Cost
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	530,990	59	8,999.83	17	152,997
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)					790,650
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,796,407
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					251
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,772.89
89.00	Observation bed cost (line 87 x line 88) (see instructions)					444,995

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1335

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

Worksheet D-1

Date/Time Prepared:
2/23/2022 7:54 pm

		Title XVIII		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	230,367	2,278,165	0.101120	444,995	44,998	90.00
91.00	Nursing Program cost	0	2,278,165	0.000000	444,995	0	91.00
92.00	Allied health cost	0	2,278,165	0.000000	444,995	0	92.00
93.00	All other Medical Education	0	2,278,165	0.000000	444,995	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1335

Period:

Worksheet D-1

Component CCN: 14-6014

From 07/01/2020
To 06/30/2021Date/Time Prepared:
2/23/2022 7:54 pm

Title XVIII

Skilled Nursing
Facility

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)	1,815	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,815	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,815	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)	1,101	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		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)	1,266,844	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)	1,266,844	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)	1,266,844	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

Health Financial Systems		HARVARD MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10				
COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-1335 Component CCN: 14-6014		Period: From 07/01/2020 To 06/30/2021		Worksheet D-1 Date/Time Prepared: 2/23/2022 7:54 pm	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description		Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)			
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)					
		1.00	2.00	3.00	4.00	5.00			
42.00	NURSERY (title V & XIX only)							42.00	
Intensive Care Type Inpatient Hospital Units									
43.00	INTENSIVE CARE UNIT							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)							48.00	
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)							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)							50.00	
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)							51.00	
52.00	Total Program excludable cost (sum of lines 50 and 51)							52.00	
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)							53.00	
TARGET AMOUNT AND LIMIT COMPUTATION									
54.00	Program discharges							54.00	
55.00	Target amount per discharge							55.00	
56.00	Target amount (line 54 x line 55)							56.00	
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							57.00	
58.00	Bonus payment (see instructions)							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							59.00	
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket							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)							61.00	
62.00	Relief payment (see instructions)							62.00	
63.00	Allowable Inpatient cost plus incentive payment (see instructions)							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)							64.00	
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)							65.00	
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)							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)							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)							68.00	
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							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)						1,266,844	70.00	
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						697.99	71.00	
72.00	Program routine service cost (line 9 x line 71)						768,487	72.00	
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						0	73.00	
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						768,487	74.00	
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						0	75.00	
76.00	Per diem capital-related costs (line 75 ÷ line 2)						0.00	76.00	
77.00	Program capital-related costs (line 9 x line 76)						0	77.00	
78.00	Inpatient routine service cost (line 74 minus line 77)						0	78.00	
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						0	79.00	
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						0	80.00	
81.00	Inpatient routine service cost per diem limitation						0.00	81.00	
82.00	Inpatient routine service cost limitation (line 9 x line 81)						0	82.00	
83.00	Reasonable inpatient routine service costs (see instructions)						768,487	83.00	
84.00	Program inpatient ancillary services (see instructions)						452,841	84.00	
85.00	Utilization review - physician compensation (see instructions)						0	85.00	
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						1,221,328	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: 14-1335
 Component CCN: 14-6014

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

 Worksheet D-1
 Date/Time Prepared:
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Title XVIII

 Skilled Nursing
 Facility

PPS

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

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1335

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

Worksheet D-1

Date/Time Prepared:
2/23/2022 7:54 pm

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)	1,285	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,285	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,034	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)	13	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		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)	2,278,165	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)	2,278,165	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)	2,278,165	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)	1,772.89	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	23,048	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)	23,048	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1335

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

Worksheet D-1

Date/Time Prepared:
2/23/2022 7:54 pm

Cost Center Description		Title XIX		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	530,990	59	8,999.83	0	0	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)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					23,048	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)					251	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,772.89	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					444,995	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1335

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

Worksheet D-1

Date/Time Prepared:
2/23/2022 7:54 pm

		Title XIX		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	230,367	2,278,165	0.101120	444,995	44,998	90.00
91.00	Nursing Program cost	0	2,278,165	0.000000	444,995	0	91.00
92.00	Allied health cost	0	2,278,165	0.000000	444,995	0	92.00
93.00	All other Medical Education	0	2,278,165	0.000000	444,995	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1335	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 2/23/2022 7:54 pm	
		Title XVIII	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		1,477,260	30.00
31.00	03100	INTENSIVE CARE UNIT		140,152	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.136168	1,187,337	50.00
51.00	05100	RECOVERY ROOM	0.355260	40,277	51.00
53.00	05300	ANESTHESIOLOGY	2.458959	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151342	291,211	54.00
60.00	06000	LABORATORY	0.358289	332,726	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.860586	14,178	65.00
66.00	06600	PHYSICAL THERAPY	0.552565	149,907	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.072069	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.075222	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.181398	574,893	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.266550	493,368	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.201829	576,274	73.00
76.97	07697	CARDIAC REHABILITATION	0.761778	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					
91.00	09100	EMERGENCY	0.681768	3,093	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.614638	3,477	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,666,741	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)		3,666,741	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1335 Component CCN: 14-6014	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 2/23/2022 7:54 pm	
		Title XVIII	Skilled Nursing Facility	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				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.136168	0	0	50.00
51.00	05100 RECOVERY ROOM	0.355260	0	0	51.00
53.00	05300 ANESTHESIOLOGY	2.458959	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.151342	14,328	2,168	54.00
60.00	06000 LABORATORY	0.358289	29,868	10,701	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.860586	1,126	969	65.00
66.00	06600 PHYSICAL THERAPY	0.552565	229,987	127,083	66.00
67.00	06700 OCCUPATIONAL THERAPY	1.072069	233,890	250,746	67.00
68.00	06800 SPEECH PATHOLOGY	1.075222	32,452	34,893	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.181398	17,465	3,168	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.266550	340	91	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.201829	35,670	7,199	73.00
76.97	07697 CARDIAC REHABILITATION	0.761778	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.681768	133	91	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.614638	25,596	15,732	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		620,855	452,841	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)		620,855		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1335	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 2/23/2022 7:54 pm
		Title XVIII	Hospital	Cost
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		4,480,455	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		5,014,953	3.00
4.00	Outlier payment (see instructions)		0	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)		4,480,455	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	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)		0	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)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	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)		4,525,260	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)		5,014,953	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		24,222	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,899,768	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)		1,601,270	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	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)		1,601,270	30.00
31.00	Primary payer payments		500	31.00
32.00	Subtotal (line 30 minus line 31)		1,600,770	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)		390,465	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		253,802	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		328,635	36.00
37.00	Subtotal (see instructions)		1,854,572	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)		1,854,572	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		2,534,669	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)		-680,097	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

Health Financial Systems		HARVARD MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1335	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 2/23/2022 7:54 pm	
		Component CCN: 14-6014			
		Title XVIII	Skilled Nursing Facility	PPS	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)		1,568	1.00	
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00	
3.00	OPPS payments			3.00	
4.00	Outlier payment (see instructions)			4.00	
4.01	Outlier reconciliation amount (see instructions)			4.01	
5.00	Enter the hospital specific payment to cost ratio (see instructions)			5.00	
6.00	Line 2 times line 5		0	6.00	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00	
8.00	Transitional corridor payment (see instructions)		0	8.00	
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00	
10.00	Organ acquisitions		0	10.00	
11.00	Total cost (sum of lines 1 and 10) (see instructions)		1,568	11.00	
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges		7,771	12.00	
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			13.00	
14.00	Total reasonable charges (sum of lines 12 and 13)		7,771	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 charge basis 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)		7,771	18.00	
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		6,203	19.00	
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00	
21.00	Lesser of cost or charges (see instructions)		1,568	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)		0	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)			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)		1,568	27.00	
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	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)		1,568	30.00	
31.00	Primary payer payments		0	31.00	
32.00	Subtotal (line 30 minus line 31)		1,568	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)		0	34.00	
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00	
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00	
37.00	Subtotal (see instructions)		1,568	37.00	
38.00	MSP-LCC reconciliation amount from PS&R			38.00	
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00	
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			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)		1,568	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			40.03	
41.00	Interim payments		1,572	41.00	
41.01	Interim payments-PARHM			41.01	
42.00	Tentative settlement (for contractors use only)		0	42.00	
42.01	Tentative settlement-PARHM (for contractor use only)			42.01	
43.00	Balance due provider/program (see instructions)		-4	43.00	
43.01	Balance due provider/program-PARHM (see instructions)			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)			90.00	
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00	
92.00	The rate used to calculate the Time Value of Money			92.00	
93.00	Time Value of Money (see instructions)			93.00	
94.00	Total (sum of lines 91 and 93)			94.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1335

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part I
Date/Time Prepared:
2/23/2022 7:54 pm

		Title XVIII		Hospital		Cost
		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		1,503,009		2,139,788	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	04/07/2021	122,952	04/07/2021	311,795	3.01
3.02		05/26/2021	20,156	05/26/2021	83,086	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		143,108		394,881	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)		1,646,117		2,534,669	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		2,440		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		680,097	6.02
7.00	Total Medicare program liability (see instructions)		1,648,557		1,854,572	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

 Provider CCN: 14-1335
 Component CCN: 14-6014

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

 Worksheet E-1
 Part I
 Date/Time Prepared:
 2/23/2022 7:54 pm

		Title XVIII		Skilled Nursing Facility		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		560,250		1,572	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		560,250		1,572	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		4	6.02
7.00	Total Medicare program liability (see instructions)		560,250		1,568	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: 14-1335

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part II
Date/Time Prepared:
2/23/2022 7:54 pm

		Title XVIII	Hospital	Cost
				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 through 12, and 32.			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8, sum of lines 1, 8 through 12, and 32.			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-1335

Period:
From 07/01/2020
To 06/30/2021Worksheet E-3
Part V
Date/Time Prepared:
2/23/2022 7:54 pm

Title XVIII		Hospital	Cost
			1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT			
1.00	Inpatient services	1,796,407	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,796,407	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,814,371	6.00
COMPUTATION OF LESSER OF COST OR CHARGES			
Reasonable charges			
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
Customary charges			
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	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	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,814,371	19.00
20.00	Deductibles (exclude professional component)	186,420	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,627,951	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,627,951	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	31,702	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	20,606	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	27,443	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,648,557	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,648,557	30.00
30.01	Sequestration adjustment (see instructions)	0	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	1,646,117	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	2,440	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-1335 Component CCN:14-6014	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part VI Date/Time Prepared: 2/23/2022 7:54 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)			638,928 1.00
2.00	Routine service other pass through costs			0 2.00
3.00	Ancillary service other pass through costs			0 3.00
4.00	Subtotal (sum of lines 1 through 3)			638,928 4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible			0 6.00
7.00	Coinsurance			78,678 7.00
8.00	Allowable bad debts (see instructions)			0 8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0 9.00
10.00	Adjusted reimbursable bad debts (see instructions)			0 10.00
11.00	Utilization review			0 11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)			560,250 12.00
13.00	Inpatient primary payer payments			0 13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 14.50
14.98	Recovery of accelerated depreciation.			0 14.98
14.99	Demonstration payment adjustment amount before sequestration			0 14.99
15.00	Subtotal (see instructions)			560,250 15.00
15.01	Sequestration adjustment (see instructions)			0 15.01
15.02	Demonstration payment adjustment amount after sequestration			0 15.02
15.75	Sequestration for non-claims based amounts (see instructions)			0 15.75
16.00	Interim payments			560,250 16.00
17.00	Tentative settlement (for contractor use only)			0 17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)			0 18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2			0 19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-1335

Period:
From 07/01/2020
To 06/30/2021Worksheet E-3
Part VII
Date/Time Prepared:
2/23/2022 7:54 pm

		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		23,048		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)		23,048	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)		23,048	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		23,048	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)		23,048	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0		28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		23,048	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		23,048	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		23,048	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		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)		23,048	0	36.00
37.00	PAYMENT		-23,048	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 14-1335

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

Worksheet G

Date/Time Prepared:
2/23/2022 7:54 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	16,665,536	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	11,574,521	0	0	0	4.00
5.00	Other receivable	16,738	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8,333,651	0	0	0	6.00
7.00	Inventory	1,061,950	0	0	0	7.00
8.00	Prepaid expenses	24,795	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	21,009,889	0	0	0	11.00
FIXED ASSETS						
12.00	Land	222,604	0	0	0	12.00
13.00	Land improvements	883,085	0	0	0	13.00
14.00	Accumulated depreciation	-721,898	0	0	0	14.00
15.00	Buildings	22,231,266	0	0	0	15.00
16.00	Accumulated depreciation	-17,327,699	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	18,631,416	0	0	0	23.00
24.00	Accumulated depreciation	-15,229,444	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)	8,689,330	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	29,699,219	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	394,269	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,091,253	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	1,348,817	0	0	0	43.00
44.00	Other current liabilities	3,934,627	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,768,966	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	13,267,694	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	13,267,694	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	20,036,660	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	9,662,559				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)	9,662,559	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	29,699,219	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1335

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

Worksheet G-1

Date/Time Prepared:
2/23/2022 7:54 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		3,868,589		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		7,244,048				2.00
3.00	Total (sum of line 1 and line 2)		11,112,637		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)		11,112,637		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	OTHER	1,450,078		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)		1,450,078		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		9,662,559		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	OTHER		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: 14-1335

Period:
From 07/01/2020
To 06/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
2/23/2022 7:54 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,751,792		3,751,792	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	760,232		760,232	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	892,447		892,447	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,404,471		5,404,471	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	441,525		441,525	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)	441,525		441,525	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,845,996		5,845,996	17.00
18.00	Ancillary services	10,601,233	52,257,256	62,858,489	18.00
19.00	Outpatient services	349,099	5,453,783	5,802,882	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
27.01	PROFESSIONAL FEES	0	3,386,092	3,386,092	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	16,796,328	61,097,131	77,893,459	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		23,163,851		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	BD	4,038,250			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)		4,038,250		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		27,202,101		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1335

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

Worksheet G-3

Date/Time Prepared:
2/23/2022 7:54 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	77,893,459	1.00
2.00	Less contractual allowances and discounts on patients' accounts	45,144,786	2.00
3.00	Net patient revenues (line 1 minus line 2)	32,748,673	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	27,202,101	4.00
5.00	Net income from service to patients (line 3 minus line 4)	5,546,572	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	74,078	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	233,196	24.00
24.50	COVID-19 PHE Funding	1,395,970	24.50
25.00	Total other income (sum of lines 6-24)	1,703,244	25.00
26.00	Total (line 5 plus line 25)	7,249,816	26.00
27.00	GRANT	5,768	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	5,768	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	7,244,048	29.00