

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: 14-2010	Period: From 06/01/2020 To 05/31/2021	Worksheet S Parts I-III Date/Time Prepared: 10/26/2021 10:25 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 10/26/2021	Time: 10:25 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RML HEALTH PROVIDERS, L.P. (14-2010) for the cost reporting period beginning 06/01/2020 and ending 05/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)_____
Title_____
Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	1,281,385	0	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	1,281,385	0	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-2010		Period: From 06/01/2020 To 05/31/2021		Worksheet S-2 Part I Date/Time Prepared: 10/26/2021 10:25 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 5601 SOUTH COUNTY LINE ROAD			PO Box:				1.00	
2.00	City: HINSDALE			State: IL		Zip Code: 60521		County: COOK 2.00	
				Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)
				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			RML HEALTH PROVIDERS, L.P.	142010	16974	2	06/01/1997	N P N 3.00
4.00	Subprovider - IPF								4.00
5.00	Subprovider - IRF								5.00
6.00	Subprovider - (Other)								6.00
7.00	Swing Beds - SNF								7.00
8.00	Swing Beds - NF								8.00
9.00	Hospital-Based SNF								9.00
10.00	Hospital-Based NF								10.00
11.00	Hospital-Based OLTC								11.00
12.00	Hospital-Based HHA								12.00
13.00	Separately Certified ASC								13.00
14.00	Hospital-Based Hospice								14.00
15.00	Hospital-Based Health Clinic - RHC								15.00
16.00	Hospital-Based Health Clinic - FQHC								16.00
17.00	Hospital-Based (CMHC) I								17.00
18.00	Renal Dialysis								18.00
19.00	Other								19.00
								From:	To:
								1.00	2.00
20.00	Cost Reporting Period (mm/dd/yyyy)						06/01/2020	05/31/2021	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 OMBdelineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.								22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						2	N	23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-2010

Period:
From 06/01/2020
To 05/31/2021Worksheet S-2
Part I
Date/Time Prepared:
10/26/2021 10:25 am

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	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.					1		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V	XVIII	
					1.00	2.00	
						XIX	
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	45.00
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	46.00
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	47.00
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	48.00
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		56.00
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.							57.00
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		58.00
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		59.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-2010		Period: From 06/01/2020 To 05/31/2021		Worksheet S-2 Part I Date/Time Prepared: 10/26/2021 10:25 am	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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From 06/01/2020
To 05/31/2021Worksheet S-2
Part I
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10/26/2021 10:25 am

			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

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

Health Financial Systems		RML HEALTH PROVIDERS, L.P.		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-2010		Period: From 06/01/2020 To 05/31/2021 Worksheet S-2 Part I Date/Time Prepared: 10/26/2021 10:25 am	
		V		XIX	
		1.00		2.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				109.00
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N		110.00	
		1.00		2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00	
		1.00		2.00	
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	
		1.00		2.00	
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.	1		118.00	
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1,839,403	25,000	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		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00	
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00	
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-2010		Period: From 06/01/2020 To 05/31/2021		Worksheet S-2 Part I Date/Time Prepared: 10/26/2021 10:25 am	
				1.00			2.00		
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							132.00	
133.00	Removed and reserved							133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.							134.00	
All Providers									
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)			Y				140.00	
				1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:			Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:			PO Box:				142.00	
143.00	City:			State:		Zip Code:		143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?					Y		144.00	
				1.00	2.00				
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			Y				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.			N				146.00	
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N		149.00	
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital			N	N	N	N	155.00	
156.00	Subprovider - IPF			N	N	N	N	156.00	
157.00	Subprovider - IRF			N	N	N	N	157.00	
158.00	SUBPROVIDER							158.00	
159.00	SNF			N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY			N	N	N	N	160.00	
161.00	CMHC				N	N	N	161.00	
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N		165.00	
				Name	County	State	Zip Code	CBSA	FTE/Campus
				0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.					N		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.00		169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-2010	Period: From 06/01/2020 To 05/31/2021	Worksheet S-2 Part I Date/Time Prepared: 10/26/2021 10:25 am
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-2010	Period: From 06/01/2020 To 05/31/2021	Worksheet S-2 Part II Date/Time Prepared: 10/26/2021 10:25 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	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 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	09/22/2021	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-2010

Period:
From 06/01/2020
To 05/31/2021Worksheet S-2
Part II
Date/Time Prepared:
10/26/2021 10:25 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JAMES		LIADIS	41.00
42.00	Enter the employer/company name of the cost report preparer.	RML			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	773-826-6380		JLIADIS@RMLSPECIALTYHOSPITAL.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-2010

Period:
From 06/01/2020
To 05/31/2021Worksheet S-2
Part II
Date/Time Prepared:
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		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	FINANCE 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: 14-2010

Period:
From 06/01/2020
To 05/31/2021Worksheet S-3
Part I
Date/Time Prepared:
10/26/2021 10:25 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	184	66,976	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		184	66,976	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		184	66,976	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
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)		184			0	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: 14-2010

Period:
From 06/01/2020
To 05/31/2021Worksheet S-3
Part I
Date/Time Prepared:
10/26/2021 10:25 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	18,783	5,202	58,302			1.00
2.00	HMO and other (see instructions)	0	12,699				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)	18,783	5,202	58,302			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)	18,783	5,202	58,302	0.00	735.60	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
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	735.60	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	3,181					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-2010

Period:
From 06/01/2020
To 05/31/2021Worksheet S-3
Part I
Date/Time Prepared:
10/26/2021 10:25 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	447	158	1,393	1.00
2.00 HMO and other (see instructions)			0	280		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	447	158	1,393	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			71			33.00
33.01 LTCH site neutral days and discharges			0			33.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-2010

Period:
From 06/01/2020
To 05/31/2021

Worksheet A

Date/Time Prepared:
10/26/2021 10:25 am

	Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		3,028,218	3,028,218	2,927,935	5,956,153	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,532,224	4,532,224	415,899	4,948,123	2.00
3.00	00300	OTHER CAP REL COSTS		3,343,834	3,343,834	-3,343,834	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	321,304	9,575,225	9,896,529	7,515	9,904,044	4.00
5.01	00560	PURCHASING	472,779	138,689	611,468	16,642	628,110	5.01
5.02	00570	ADMITTING	1,685,780	168,347	1,854,127	44,565	1,898,692	5.02
5.03	00580	PATIENT ACCOUNTS	561,125	141,301	702,426	12,435	714,861	5.03
5.04	00590	OTHER A&G	8,413,064	11,566,680	19,979,744	-657,668	19,322,076	5.04
6.00	00600	MAINTENANCE & REPAIRS	186,275	171,352	357,627	5,912	363,539	6.00
7.00	00700	OPERATION OF PLANT	1,839,028	1,994,393	3,833,421	28,015	3,861,436	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	257,540	257,540	0	257,540	8.00
9.00	00900	HOUSEKEEPING	1,165,778	469,021	1,634,799	25,722	1,660,521	9.00
10.00	01000	DIETARY	831,315	463,321	1,294,636	-158,389	1,136,247	10.00
11.00	01100	CAFETERIA	0	0	0	175,951	175,951	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,215,915	91,885	1,307,800	51,457	1,359,257	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	331,496	66,160	397,656	9,400	407,056	16.00
17.00	01700	SOCIAL SERVICE	1,639,505	438,165	2,077,670	29,057	2,106,727	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	21,434,353	9,019,650	30,454,003	-2,382,885	28,071,118	30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	560,571	590,106	1,150,677	-385,067	765,610	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	820,648	295,019	1,115,667	12,861	1,128,528	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	145,596	1,500,683	1,646,279	2,449	1,648,728	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	8,632,118	2,403,869	11,035,987	-1,101,638	9,934,349	65.00
66.00	06600	PHYSICAL THERAPY	1,326,188	130,440	1,456,628	-6,715	1,449,913	66.00
67.00	06700	OCCUPATIONAL THERAPY	746,918	62,273	809,191	-998	808,193	67.00
68.00	06800	SPEECH PATHOLOGY	482,730	43,766	526,496	4,134	530,630	68.00
68.01	03550	PSYCHOLOGY	0	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,152,097	4,152,097	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,621,588	4,237,462	5,859,050	196,027	6,055,077	73.00
74.00	07400	RENAL DIALYSIS	0	2,565,511	2,565,511	-67	2,565,444	74.00
75.01	03630	ULTRASOUND	80,411	27,703	108,114	616	108,730	75.01
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							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS						92.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	54,514,485	57,322,837	111,837,322	81,428	111,918,750	118.00
	NONREIMBURSABLE COST CENTERS							
190.01	19002	IDLE SPACE	0	0	0	0	0	190.01
194.00	07950	PSYCHOLOGY	300,458	22,637	323,095	-81,428	241,667	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	54,814,943	57,345,474	112,160,417	0	112,160,417	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-2010

Period:
From 06/01/2020
To 05/31/2021Worksheet A
Date/Time Prepared:
10/26/2021 10:25 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,047,552	4,908,601	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-959,481	3,988,642	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,904,044	4.00
5.01	00560	PURCHASING	0	628,110	5.01
5.02	00570	ADMITTING	0	1,898,692	5.02
5.03	00580	PATIENT ACCOUNTS	0	714,861	5.03
5.04	00590	OTHER A&G	-8,616,656	10,705,420	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	363,539	6.00
7.00	00700	OPERATION OF PLANT	0	3,861,436	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	257,540	8.00
9.00	00900	HOUSEKEEPING	0	1,660,521	9.00
10.00	01000	DIETARY	-8,091	1,128,156	10.00
11.00	01100	CAFETERIA	-38,057	137,894	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,359,257	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	-906	406,150	16.00
17.00	01700	SOCIAL SERVICE	0	2,106,727	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	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	-1,553,700	26,517,418	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	765,610	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,020	1,127,508	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
60.00	06000	LABORATORY	-30,000	1,618,728	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	-1,041,841	8,892,508	65.00
66.00	06600	PHYSICAL THERAPY	0	1,449,913	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	808,193	67.00
68.00	06800	SPEECH PATHOLOGY	0	530,630	68.00
68.01	03550	PSYCHOLOGY	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,152,097	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-78	6,054,999	73.00
74.00	07400	RENAL DIALYSIS	0	2,565,444	74.00
75.01	03630	ULTRASOUND	0	108,730	75.01
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					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-13,297,382	98,621,368	118.00
NONREIMBURSABLE COST CENTERS					
190.01	19002	IDLE SPACE	0	0	190.01
194.00	07950	PSYCHOLOGY	0	241,667	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-13,297,382	98,863,035	200.00

RECLASSIFICATIONS

Provider CCN: 14-2010

Period:
From 06/01/2020
To 05/31/2021

Worksheet A-6

Date/Time Prepared:
10/26/2021 10:25 am

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - RECLASS CAFETERIA COST FROM DIETARY					
1.00	CAFETERIA	11.00	111,470	62,126	1.00
	TOTALS		111,470	62,126	
B - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	4,152,097	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
	TOTALS		0	4,152,097	
C - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	164,399	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	TOTALS		0	164,399	
D - SALARY RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	7,515	0	1.00
2.00	PURCHASING	5.01	16,642	0	2.00
3.00	ADMITTING	5.02	44,565	0	3.00
4.00	PATIENT ACCOUNTS	5.03	12,435	0	4.00
6.00	MAINTENANCE & REPAIRS	6.00	5,912	0	6.00
7.00	OPERATION OF PLANT	7.00	28,015	0	7.00
8.00	HOUSEKEEPING	9.00	25,722	0	8.00
9.00	DIETARY	10.00	15,207	0	9.00
10.00	CAFETERIA	11.00	2,355	0	10.00
11.00	NURSING ADMINISTRATION	13.00	51,457	0	11.00
12.00	MEDICAL RECORDS & LIBRARY	16.00	9,400	0	12.00
13.00	SOCIAL SERVICE	17.00	29,057	0	13.00
14.00	ADULTS & PEDIATRICS	30.00	244,381	0	14.00
15.00	OPERATING ROOM	50.00	4,075	0	15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	12,861	0	16.00
17.00	LABORATORY	60.00	2,449	0	17.00
18.00	RESPIRATORY THERAPY	65.00	147,611	0	18.00
19.00	PHYSICAL THERAPY	66.00	19,667	0	19.00
20.00	OCCUPATIONAL THERAPY	67.00	7,120	0	20.00
21.00	SPEECH PATHOLOGY	68.00	4,134	0	21.00
22.00	DRUGS CHARGED TO PATIENTS	73.00	31,628	0	22.00
23.00	ULTRASOUND	75.01	616	0	23.00
24.00	PSYCHOLOGY	194.00	5,314	0	24.00
	TOTALS		728,138	0	
E - BUILDING INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	877,232	1.00
	TOTALS		0	877,232	
H - PSYCHOLOGY ADMIN					
1.00	OTHER A&G	5.04	76,084	10,658	1.00
	TOTALS		76,084	10,658	
500.00	Grand Total: Increases		915,692	5,266,512	500.00

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS CAFETERIA COST FROM DIETARY						
1.00	DIETARY	10.00	111,470	62,126	0		1.00
	TOTALS		111,470	62,126			
	B - MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	2,480,962	0		1.00
2.00	OPERATING ROOM	50.00	0	387,802	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	1,248,833	0		3.00
4.00	PHYSICAL THERAPY	66.00	0	26,382	0		4.00
5.00	OCCUPATIONAL THERAPY	67.00	0	8,118	0		5.00
	TOTALS		0	4,152,097			
	C - DRUGS						
1.00	OTHER A&G	5.04	0	16,272	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	146,304	0		2.00
3.00	OPERATING ROOM	50.00	0	1,340	0		3.00
5.00	RESPIRATORY THERAPY	65.00	0	416	0		5.00
6.00	RENAL DIALYSIS	74.00	0	67	0		6.00
	TOTALS		0	164,399			
	D - SALARY RECLASS						
1.00	OTHER A&G	5.04	728,138	0	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
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
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
	TOTALS		728,138	0			
	E - BUILDING INTEREST EXPENSE						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	877,232	11		1.00
	TOTALS		0	877,232			
	H - PSYCHOLOGY ADMIN						
1.00	PSYCHOLOGY	194.00	76,084	10,658	0		1.00
	TOTALS		76,084	10,658			
500.00	Grand Total: Decreases		915,692	5,266,512			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-2010

Period:
From 06/01/2020
To 05/31/2021Worksheet A-7
Part I
Date/Time Prepared:
10/26/2021 10:25 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0	0	0	0	1.00	
2.00	Land Improvements	0	0	0	0	0	2.00	
3.00	Buildings and Fixtures	39,390,234	0	0	0	0	3.00	
4.00	Building Improvements	14,174,712	1,782,410	0	1,782,410	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	32,002,616	2,898,279	0	2,898,279	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	85,567,562	4,680,689	0	4,680,689	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	85,567,562	4,680,689	0	4,680,689	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0				1.00	
2.00	Land Improvements	0	0				2.00	
3.00	Buildings and Fixtures	39,390,234	0				3.00	
4.00	Building Improvements	15,957,122	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	34,900,895	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	90,248,251	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	90,248,251	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-2010

Period:
From 06/01/2020
To 05/31/2021Worksheet A-7
Part II
Date/Time Prepared:
10/26/2021 10:25 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,678,901	1,349,317	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,180,973	0	2,351,251	0	0	2.00
3.00	Total (sum of lines 1-2)	3,859,874	1,349,317	2,351,251	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	3,028,218				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4,532,224				2.00
3.00	Total (sum of lines 1-2)	0	7,560,442				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-2010

Period:
From 06/01/2020
To 05/31/2021Worksheet A-7
Part III
Date/Time Prepared:
10/26/2021 10:25 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
		1.00	2.00	3.00	4.00	5.00		
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	55,347,356	0	55,347,356	0.613279	2,050,703	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	34,900,895	0	34,900,895	0.386721	1,293,131	2.00	
3.00	Total (sum of lines 1-2)	90,248,251	0	90,248,251	1.000000	3,343,834	3.00	
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
		6.00	7.00	8.00	9.00	10.00		
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	2,050,703	1,678,901	301,765	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	1,293,131	2,180,973	0	2.00	
3.00	Total (sum of lines 1-2)	0	0	3,343,834	3,859,874	301,765	3.00	
Cost Center Description		SUMMARY OF CAPITAL						
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
		11.00	12.00	13.00	14.00	15.00		
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	877,232	2,050,703	0	0	4,908,601	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	514,538	1,293,131	0	0	3,988,642	2.00	
3.00	Total (sum of lines 1-2)	1,391,770	3,343,834	0	0	8,897,243	3.00	

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-2010

Period:
From 06/01/2020
To 05/31/2021

Worksheet A-8

Date/Time Prepared:
10/26/2021 10:25 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00				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)	B	-959,481	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)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,960,474			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	-1,047,552			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-38,057	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-906	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	MARKETING	A	-12,057	OTHER A&G	5.04	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-2010

Period:
From 06/01/2020
To 05/31/2021

Worksheet A-8

Date/Time Prepared:
10/26/2021 10:25 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
33.01	MEDICAL RECORDS	B		0MEDICAL RECORDS & LIBRARY	16.00	0	33.01
33.02	OTHER INCOME	B		0NURSING ADMINISTRATION	13.00	0	33.02
33.05	RESEARCH AND DEVELOPMENT	A	-144,167	0OTHER A&G	5.04	0	33.05
33.06	MARKETING	A		0ADMITTING	5.02	0	33.06
33.07	PULMONARY EXPENSE	A	-1,041,824	0RESPIRATORY THERAPY	65.00	0	33.07
33.10	OTHER REVENUE - NURSING	B	-36	0ADULTS & PEDIATRICS	30.00	0	33.10
33.11	OTHER REVENUE - FACILITY OPERAT	B		0OPERATION OF PLANT	7.00	0	33.11
33.13	OTHER REVENUE - SOCIAL SERVICES	B		0SOCIAL SERVICE	17.00	0	33.13
33.16	OTHER REVENUE - DIETARY	B	-8,091	0DIETARY	10.00	0	33.16
33.17	OTHER REVENUE - RADIOLOGY	B	-1,020	0RADIOLOGY-DIAGNOSTIC	54.00	0	33.17
33.19	DONATIONS	A	-5,000	0OTHER A&G	5.04	0	33.19
33.22	ENTERTAINMENT EXPENSE	A	-10,699	0OTHER A&G	5.04	0	33.22
33.23	MEMBERSHIP DUES	A	-77,367	0OTHER A&G	5.04	0	33.23
33.24	UNFUNDED SELF INSURANCE	A	-1,814,403	0OTHER A&G	5.04	0	33.24
33.31	OTHER REVENUE-PATIENTS ACCOUNTS	A		0PATIENT ACCOUNTS	5.03	0	33.31
33.34	OTHER REVENUE - PHYCICAL THERAP	B		0PHYSICAL THERAPY	66.00	0	33.34
35.00	PROVIDER RELATIONS MARKETING	A	-71,820	0OTHER A&G	5.04	0	35.00
37.00	OTHER REVENUE - ACCOUNTING	B		0OTHER A&G	5.04	0	37.00
38.00	MEDICAID PROVIDER TAX - SUPPLEM	A	-6,085,889	0OTHER A&G	5.04	0	38.00
39.00	PULMONARY PHYSCIAN BENEFITS	A		0EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.00
41.00	OTHER REVENUE - A&G	B	-18,444	0OTHER A&G	5.04	0	41.00
46.00	OTHER INCOME	B	-17	0RESPIRATORY THERAPY	65.00	0	46.00
47.00	BAD DEBTS	B	-78	0DRUGS CHARGED TO PATIENTS	73.00	0	47.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-13,297,382				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: 14-2010

Period:
From 06/01/2020
To 05/31/2021

Worksheet A-8-1

Date/Time Prepared:
10/26/2021 10:25 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	ADVOCATE BUILDING COST	561,387	1,608,939	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	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			561,387	1,608,939	5.00

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

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office		
	1.00	2.00	3.00	Name	Percentage of Ownership	
	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	LOYOLA UNIVERSI	49.50	LOYOLA UNIVERSITY MEDICAL CENTER	49.50	6.00
7.00	B	ADVOCATE HEALTH	49.50	ADVOCATE HEALTH AND HOSPITALS	49.50	7.00
8.00	B	RMLHP CORPORATI	1.00	RMLHP CORPORATION	1.00	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: 14-2010

Period:
From 06/01/2020
To 05/31/2021

Worksheet A-8-1

Date/Time Prepared:
10/26/2021 10:25 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-1,047,552	10		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-1,047,552			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	HOSPITAL		6.00
7.00	HOSPITAL		7.00
8.00	CORPORATION		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: 14-2010

Period:
From 06/01/2020
To 05/31/2021

Worksheet A-8-2

Date/Time Prepared:
10/26/2021 10:25 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.04	AGGREGATE-OTHER A&G	481,747	267,354	214,393	211,500	1,032	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	1,553,664	1,553,664	0	179,000	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	60.00	AGGREGATE-LABORATORY	30,000	30,000	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,065,411	1,851,018	214,393		1,032	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.04	AGGREGATE-OTHER A&G	104,937	5,247	0	0	0	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	60.00	AGGREGATE-LABORATORY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			104,937	5,247	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.04	AGGREGATE-OTHER A&G	0	104,937	109,456	376,810		1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	1,553,664		2.00
3.00	0.00		0	0	0	0		3.00
4.00	60.00	AGGREGATE-LABORATORY	0	0	0	30,000		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	104,937	109,456	1,960,474		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-2010

Period:
From 06/01/2020
To 05/31/2021Worksheet B
Part I
Date/Time Prepared:
10/26/2021 10:25 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	PURCHASING	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	5.01
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,908,601	4,908,601			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,988,642		3,988,642		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,904,044	121,854	3,909	10,029,807	4.00
5.01	00500	PURCHASING	628,110	132,950	7,147	90,093	5.01
5.02	00570	ADMITTING	1,898,692	72,514	4,565	318,522	5.02
5.03	00580	PATIENT ACCOUNTS	714,861	44,386	1,140	105,581	5.03
5.04	00590	OTHER A&G	10,705,420	1,502,628	1,645,476	1,428,647	5.04
6.00	00600	MAINTENANCE & REPAIRS	363,539	89,700	1,989	35,378	6.00
7.00	00700	OPERATION OF PLANT	3,861,436	377,716	177,191	343,685	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	257,540	75,404	8,287	0	8.00
9.00	00900	HOUSEKEEPING	1,660,521	74,733	25,721	219,331	9.00
10.00	01000	DIETARY	1,128,156	274,003	86,903	135,308	10.00
11.00	01100	CAFETERIA	137,894	121,673	13,457	20,953	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,359,257	34,270	716	233,298	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	406,150	62,114	7,184	62,752	16.00
17.00	01700	SOCIAL SERVICE	2,106,727	45,160	2,402	307,149	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	26,517,418	1,238,227	1,117,452	3,990,623	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	765,610	67,043	66,209	103,940	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,127,508	116,280	497,216	153,432	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
60.00	06000	LABORATORY	1,618,728	0	3,934	27,252	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	8,892,508	88,023	192,098	1,616,173	65.00
66.00	06600	PHYSICAL THERAPY	1,449,913	43,947	19,010	247,745	66.00
67.00	06700	OCCUPATIONAL THERAPY	808,193	28,954	0	138,803	67.00
68.00	06800	SPEECH PATHOLOGY	530,630	25,780	1,195	89,622	68.00
68.01	03550	PSYCHOLOGY	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,152,097	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,054,999	116,460	80,172	304,324	73.00
74.00	07400	RENAL DIALYSIS	2,565,444	8,000	1,289	0	74.00
75.01	03630	ULTRASOUND	108,730	7,432	23,698	14,915	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	98,621,368	4,769,251	3,988,360	9,987,526	118.00
NONREIMBURSABLE COST CENTERS							
190.01	19002	IDLE SPACE	0	127,944	0	0	190.01
194.00	07950	PSYCHOLOGY	241,667	11,406	282	42,281	194.00
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)	98,863,035	4,908,601	3,988,642	10,029,807	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-2010

Period:
From 06/01/2020
To 05/31/2021Worksheet B
Part I
Date/Time Prepared:
10/26/2021 10:25 am

Cost Center Description			ADMITTING	PATIENT ACCOUNTS	Subtotal	OTHER A&G	MAINTENANCE & REPAIRS	
			5.02	5.03	5A.03	5.04	6.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING						5.01
5.02	00570	ADMITTING	2,294,293					5.02
5.03	00580	PATIENT ACCOUNTS	0	865,968				5.03
5.04	00590	OTHER A&G	0	0	15,317,143	15,317,143		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	497,208	91,157	588,365	6.00
7.00	00700	OPERATION OF PLANT	0	0	4,772,329	874,949	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	341,231	62,561	0	8.00
9.00	00900	HOUSEKEEPING	0	0	1,982,153	363,404	0	9.00
10.00	01000	DIETARY	0	0	1,635,735	299,892	0	10.00
11.00	01100	CAFETERIA	0	0	295,737	54,220	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,627,541	298,390	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	0	541,241	99,230	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	2,465,918	452,096	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	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	1,054,736	398,039	34,384,653	6,304,020	500,788	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,275	4,256	1,018,859	186,796	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,206	14,045	1,947,259	357,007	542	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	89,750	33,880	1,827,561	335,061	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	482,454	182,126	11,461,953	2,101,412	85,679	65.00
66.00	06600	PHYSICAL THERAPY	33,974	12,825	1,807,416	331,368	1,356	66.00
67.00	06700	OCCUPATIONAL THERAPY	28,266	10,670	1,014,886	186,067	0	67.00
68.00	06800	SPEECH PATHOLOGY	21,423	8,087	676,809	124,085	0	68.00
68.01	03550	PSYCHOLOGY	0	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	171,320	64,673	4,713,730	864,206	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	281,149	106,133	7,265,350	1,332,015	0	73.00
74.00	07400	RENAL DIALYSIS	76,404	28,842	2,681,240	491,573	0	74.00
75.01	03630	ULTRASOUND	6,336	2,392	163,503	29,976	0	75.01
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								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,294,293	865,968	98,439,455	15,239,485	588,365	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19002	IDLE SPACE	0	0	127,944	23,457	0	190.01
194.00	07950	PSYCHOLOGY	0	0	295,636	54,201	0	194.00
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,294,293	865,968	98,863,035	15,317,143	588,365	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-2010

Period:
From 06/01/2020
To 05/31/2021Worksheet B
Part I
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Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	PATIENT ACCOUNTS						5.03
5.04	00590	OTHER A&G						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	5,647,278					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	165,894	569,686				8.00
9.00	00900	HOUSEKEEPING	164,418	0	2,509,975			9.00
10.00	01000	DIETARY	602,829	0	284,577	2,823,033		10.00
11.00	01100	CAFETERIA	267,691	0	126,368	0	744,016	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	75,396	0	35,592	0	18,523	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	136,656	0	64,511	0	6,984	16.00
17.00	01700	SOCIAL SERVICE	99,355	0	46,902	0	29,220	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,724,198	569,686	1,286,011	2,823,033	446,234	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	147,500	0	69,630	0	7,492	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	255,825	0	120,767	0	13,421	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	4,554	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	193,657	0	91,419	0	146,127	65.00
66.00	06600	PHYSICAL THERAPY	96,687	0	45,643	0	23,932	66.00
67.00	06700	OCCUPATIONAL THERAPY	63,701	0	30,071	0	11,191	67.00
68.00	06800	SPEECH PATHOLOGY	56,717	0	26,775	0	8,106	68.00
68.01	03550	PSYCHOLOGY	0	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	256,222	0	120,955	0	23,144	73.00
74.00	07400	RENAL DIALYSIS	17,600	0	8,308	0	0	74.00
75.01	03630	ULTRASOUND	16,351	0	7,719	0	1,042	75.01
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								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,340,697	569,686	2,365,248	2,823,033	739,970	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19002	IDLE SPACE	281,487	0	132,881	0	0	190.01
194.00	07950	PSYCHOLOGY	25,094	0	11,846	0	4,046	194.00
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)	5,647,278	569,686	2,509,975	2,823,033	744,016	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			12.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	PATIENT ACCOUNTS						5.03
5.04	00590	OTHER A&G						5.04
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	0					12.00
13.00	01300	NURSING ADMINISTRATION	0	2,055,442				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0			14.00
15.00	01500	PHARMACY	0	0	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	848,622	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	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	2,021,502	0	0	390,058	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	33,940	0	0	4,171	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	13,764	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	33,202	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	178,480	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	12,568	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	10,457	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	7,925	68.00
68.01	03550	PSYCHOLOGY	0	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	63,379	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	104,009	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	28,265	74.00
75.01	03630	ULTRASOUND	0	0	0	0	2,344	75.01
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								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,055,442	0	0	848,622	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19002	IDLE SPACE	0	0	0	0	0	190.01
194.00	07950	PSYCHOLOGY	0	0	0	0	0	194.00
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	2,055,442	0	0	848,622	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-2010

Period:
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To 05/31/2021Worksheet B
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Cost Center Description		SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS		
					SERVICES-SALAR Y & FRINGES	SERVICES-OTHER	
					APPRV	PRGM COSTS APPRV	
		17.00	19.00	20.00	21.00	22.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00560	PURCHASING					5.01
5.02	00570	ADMITTING					5.02
5.03	00580	PATIENT ACCOUNTS					5.03
5.04	00590	OTHER A&G					5.04
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	3,093,491				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0		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				23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,093,491	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
68.01	03550	PSYCHOLOGY	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.01	03630	ULTRASOUND	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,093,491	0	0	0	118.00
NONREIMBURSABLE COST CENTERS							
190.01	19002	IDLE SPACE	0	0	0	0	190.01
194.00	07950	PSYCHOLOGY	0	0	0	0	194.00
200.00		Cross Foot Adjustments		0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,093,491	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00560	PURCHASING					5.01
5.02	00570	ADMITTING					5.02
5.03	00580	PATIENT ACCOUNTS					5.03
5.04	00590	OTHER A&G					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
20.00	02000	NURSING SCHOOL					20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV					22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	54,543,674	0	54,543,674	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,468,388	0	1,468,388	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,708,585	0	2,708,585	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
60.00	06000	LABORATORY	0	2,200,378	0	2,200,378	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	14,258,727	0	14,258,727	65.00
66.00	06600	PHYSICAL THERAPY	0	2,318,970	0	2,318,970	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,316,373	0	1,316,373	67.00
68.00	06800	SPEECH PATHOLOGY	0	900,417	0	900,417	68.00
68.01	03550	PSYCHOLOGY	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,641,315	0	5,641,315	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,101,695	0	9,101,695	73.00
74.00	07400	RENAL DIALYSIS	0	3,226,986	0	3,226,986	74.00
75.01	03630	ULTRASOUND	0	220,935	0	220,935	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	97,906,443	0	97,906,443	118.00
NONREIMBURSABLE COST CENTERS							
190.01	19002	IDLE SPACE	0	565,769	0	565,769	190.01
194.00	07950	PSYCHOLOGY	0	390,823	0	390,823	194.00
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	98,863,035	0	98,863,035	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-2010

Period:
From 06/01/2020
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	121,854	3,909	125,763	4.00
5.01	00560	PURCHASING	0	132,950	7,147	140,097	5.01
5.02	00570	ADMITTING	0	72,514	4,565	77,079	5.02
5.03	00580	PATIENT ACCOUNTS	0	44,386	1,140	45,526	5.03
5.04	00590	OTHER A&G	1,515	1,502,628	1,645,476	3,149,619	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	89,700	1,989	91,689	6.00
7.00	00700	OPERATION OF PLANT	0	377,716	177,191	554,907	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	75,404	8,287	83,691	8.00
9.00	00900	HOUSEKEEPING	0	74,733	25,721	100,454	9.00
10.00	01000	DIETARY	521	274,003	86,903	361,427	10.00
11.00	01100	CAFETERIA	81	121,673	13,457	135,211	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	34,270	716	34,986	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	62,114	7,184	69,298	16.00
17.00	01700	SOCIAL SERVICE	0	45,160	2,402	47,562	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	598,921	1,238,227	1,117,452	2,954,600	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	67,043	66,209	133,252	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	116,280	497,216	613,496	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	3,934	3,934	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	40,163	88,023	192,098	320,284	65.00
66.00	06600	PHYSICAL THERAPY	0	43,947	19,010	62,957	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	28,954	0	28,954	67.00
68.00	06800	SPEECH PATHOLOGY	0	25,780	1,195	26,975	68.00
68.01	03550	PSYCHOLOGY	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	116,460	80,172	196,632	73.00
74.00	07400	RENAL DIALYSIS	0	8,000	1,289	9,289	74.00
75.01	03630	ULTRASOUND	0	7,432	23,698	31,130	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	641,201	4,769,251	3,988,360	9,398,812	118.00
NONREIMBURSABLE COST CENTERS							
190.01	19002	IDLE SPACE	0	127,944	0	127,944	190.01
194.00	07950	PSYCHOLOGY	0	11,406	282	11,688	194.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	641,201	4,908,601	3,988,642	9,538,444	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			PURCHASING	ADMITTING	PATIENT ACCOUNTS	OTHER A&G	MAINTENANCE & REPAIRS	
			5.01	5.02	5.03	5.04	6.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING	141,227					5.01
5.02	00570	ADMITTING	0	81,073				5.02
5.03	00580	PATIENT ACCOUNTS	0	0	46,850			5.03
5.04	00590	OTHER A&G	5,755	0	0	3,173,286		5.04
6.00	00600	MAINTENANCE & REPAIRS	1,086	0	0	18,885	112,104	6.00
7.00	00700	OPERATION OF PLANT	2,024	0	0	181,267	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	12,961	0	8.00
9.00	00900	HOUSEKEEPING	304	0	0	75,288	0	9.00
10.00	01000	DIETARY	1,870	0	0	62,130	0	10.00
11.00	01100	CAFETERIA	290	0	0	11,233	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	61,819	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	500	0	0	20,558	0	16.00
17.00	01700	SOCIAL SERVICE	737	0	0	93,663	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	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	11,215	37,256	21,465	1,305,996	95,418	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	87	399	231	38,699	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	259	1,315	762	73,963	103	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	8,888	3,173	1,838	69,416	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,410	17,054	9,880	435,359	16,325	65.00
66.00	06600	PHYSICAL THERAPY	0	1,201	696	68,651	258	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	999	579	38,548	0	67.00
68.00	06800	SPEECH PATHOLOGY	12	757	439	25,707	0	68.00
68.01	03550	PSYCHOLOGY	0	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	53,579	6,056	3,508	179,042	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	53,003	9,938	5,757	275,960	0	73.00
74.00	07400	RENAL DIALYSIS	208	2,701	1,565	101,842	0	74.00
75.01	03630	ULTRASOUND	0	224	130	6,210	0	75.01
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								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	141,227	81,073	46,850	3,157,197	112,104	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19002	IDLE SPACE	0	0	0	4,860	0	190.01
194.00	07950	PSYCHOLOGY	0	0	0	11,229	0	194.00
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)	141,227	81,073	46,850	3,173,286	112,104	202.00

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Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	PATIENT ACCOUNTS						5.03
5.04	00590	OTHER A&G						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	742,507					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	21,812	118,464				8.00
9.00	00900	HOUSEKEEPING	21,618	0	200,414			9.00
10.00	01000	DIETARY	79,260	0	22,723	529,107		10.00
11.00	01100	CAFETERIA	35,196	0	10,090	0	192,283	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	9,913	0	2,842	0	4,787	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	17,968	0	5,151	0	1,805	16.00
17.00	01700	SOCIAL SERVICE	13,063	0	3,745	0	7,552	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	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	358,181	118,464	102,684	529,107	115,324	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	19,393	0	5,560	0	1,936	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	33,636	0	9,643	0	3,469	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	1,177	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	25,462	0	7,300	0	37,765	65.00
66.00	06600	PHYSICAL THERAPY	12,712	0	3,644	0	6,185	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,375	0	2,401	0	2,892	67.00
68.00	06800	SPEECH PATHOLOGY	7,457	0	2,138	0	2,095	68.00
68.01	03550	PSYCHOLOGY	0	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,688	0	9,658	0	5,981	73.00
74.00	07400	RENAL DIALYSIS	2,314	0	663	0	0	74.00
75.01	03630	ULTRASOUND	2,150	0	616	0	269	75.01
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								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	702,198	118,464	188,858	529,107	191,237	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19002	IDLE SPACE	37,010	0	10,610	0	0	190.01
194.00	07950	PSYCHOLOGY	3,299	0	946	0	1,046	194.00
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)	742,507	118,464	200,414	529,107	192,283	202.00

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Cost Center Description			MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			12.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	PATIENT ACCOUNTS						5.03
5.04	00590	OTHER A&G						5.04
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	0					12.00
13.00	01300	NURSING ADMINISTRATION	0	117,272				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0			14.00
15.00	01500	PHARMACY	0	0	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	116,067	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	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	115,336	0	0	53,363	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,936	0	0	570	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	1,882	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	4,540	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	24,405	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	1,719	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	1,430	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	1,084	68.00
68.01	03550	PSYCHOLOGY	0	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	8,666	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	14,222	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	3,865	74.00
75.01	03630	ULTRASOUND	0	0	0	0	321	75.01
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								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	117,272	0	0	116,067	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19002	IDLE SPACE	0	0	0	0	0	190.01
194.00	07950	PSYCHOLOGY	0	0	0	0	0	194.00
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	117,272	0	0	116,067	202.00

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Cost Center Description		SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS		
					SERVICES-SALAR Y & FRINGES	SERVICES-OTHER	
					APPRV	PRGM COSTS APPRV	
		17.00	19.00	20.00	21.00	22.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00560	PURCHASING					5.01
5.02	00570	ADMITTING					5.02
5.03	00580	PATIENT ACCOUNTS					5.03
5.04	00590	OTHER A&G					5.04
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	170,173				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0		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				23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	170,173				30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0				50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0				54.00
56.00	05600	RADIOISOTOPE	0				56.00
60.00	06000	LABORATORY	0				60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0				62.30
65.00	06500	RESPIRATORY THERAPY	0				65.00
66.00	06600	PHYSICAL THERAPY	0				66.00
67.00	06700	OCCUPATIONAL THERAPY	0				67.00
68.00	06800	SPEECH PATHOLOGY	0				68.00
68.01	03550	PSYCHOLOGY	0				68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0				71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0				73.00
74.00	07400	RENAL DIALYSIS	0				74.00
75.01	03630	ULTRASOUND	0				75.01
76.97	07697	CARDIAC REHABILITATION	0				76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0				76.98
76.99	07699	LITHOTRIPSY	0				76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	170,173	0	0	0	118.00
NONREIMBURSABLE COST CENTERS							
190.01	19002	IDLE SPACE	0				190.01
194.00	07950	PSYCHOLOGY	0				194.00
200.00		Cross Foot Adjustments		0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	170,173	0	0	0	202.00

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Cost Center Description			PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00560	PURCHASING					5.01
5.02	00570	ADMITTING					5.02
5.03	00580	PATIENT ACCOUNTS					5.03
5.04	00590	OTHER A&G					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
20.00	02000	NURSING SCHOOL					20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV					22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		6,038,623	0	6,038,623	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		203,366	0	203,366	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		740,452	0	740,452	54.00
56.00	05600	RADIOISOTOPE		0	0	0	56.00
60.00	06000	LABORATORY		93,308	0	93,308	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY		915,508	0	915,508	65.00
66.00	06600	PHYSICAL THERAPY		161,129	0	161,129	66.00
67.00	06700	OCCUPATIONAL THERAPY		85,918	0	85,918	67.00
68.00	06800	SPEECH PATHOLOGY		67,788	0	67,788	68.00
68.01	03550	PSYCHOLOGY		0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		250,851	0	250,851	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		608,655	0	608,655	73.00
74.00	07400	RENAL DIALYSIS		122,447	0	122,447	74.00
75.01	03630	ULTRASOUND		41,237	0	41,237	75.01
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							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	9,329,282	0	9,329,282	118.00
NONREIMBURSABLE COST CENTERS							
190.01	19002	IDLE SPACE		180,424	0	180,424	190.01
194.00	07950	PSYCHOLOGY		28,738	0	28,738	194.00
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	9,538,444	0	9,538,444	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-2010

Period:
From 06/01/2020
To 05/31/2021

Worksheet B-1

Date/Time Prepared:
10/26/2021 10:25 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	PURCHASING (SUPPLIES EXPENSE)	ADMITTING (GROSS REVENUE)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	190,215					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		24,096,143				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,722	23,614	54,486,124			4.00
5.01	00560	PURCHASING	5,152	43,177	489,421	10,943,875		5.01
5.02	00570	ADMITTING	2,810	27,581	1,730,345	0	279,653,940	5.02
5.03	00580	PATIENT ACCOUNTS	1,720	6,884	573,560	0	0	5.03
5.04	00590	OTHER A&G	58,229	9,940,616	7,761,010	445,913	0	5.04
6.00	00600	MAINTENANCE & REPAIRS	3,476	12,016	192,187	84,182	0	6.00
7.00	00700	OPERATION OF PLANT	14,637	1,070,446	1,867,043	156,848	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,922	50,064	0	0	0	8.00
9.00	00900	HOUSEKEEPING	2,896	155,387	1,191,500	23,548	0	9.00
10.00	01000	DIETARY	10,618	524,998	735,052	144,915	0	10.00
11.00	01100	CAFETERIA	4,715	81,297	113,825	22,440	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,328	4,323	1,267,372	0	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	2,407	43,397	340,896	38,771	0	16.00
17.00	01700	SOCIAL SERVICE	1,750	14,508	1,668,562	57,121	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	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	47,983	6,750,751	21,678,734	869,069	128,562,144	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,598	399,979	564,646	6,707	1,374,304	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,506	3,003,781	833,509	20,043	4,535,055	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	23,765	148,045	688,749	10,939,725	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	3,411	1,160,502	8,779,729	109,281	58,807,160	65.00
66.00	06600	PHYSICAL THERAPY	1,703	114,845	1,345,855	24	4,141,184	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,122	0	754,038	1	3,445,423	67.00
68.00	06800	SPEECH PATHOLOGY	999	7,218	486,864	917	2,611,329	68.00
68.01	03550	PSYCHOLOGY	0	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,152,096	20,882,538	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,513	484,336	1,653,216	4,107,169	34,269,707	73.00
74.00	07400	RENAL DIALYSIS	310	7,789	0	16,081	9,313,013	74.00
75.01	03630	ULTRASOUND	288	143,165	81,027	0	772,358	75.01
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								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	184,815	24,094,439	54,256,436	10,943,875	279,653,940	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19002	IDLE SPACE	4,958	0	0	0	0	190.01
194.00	07950	PSYCHOLOGY	442	1,704	229,688	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,908,601	3,988,642	10,029,807	858,300	2,294,293	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	25.805541	0.165530	0.184080	0.078427	0.008204	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			125,763	141,227	81,073	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002308	0.012905	0.000290	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: 14-2010

Period:
From 06/01/2020
To 05/31/2021

Worksheet B-1

Date/Time Prepared:
10/26/2021 10:25 am

Cost Center Description		PATIENT ACCOUNTS (GROSS REVE NUE)	Reconciliation	OTHER A&G (ACCUM. COST)	MAINTENANCE & REPAIRS (WORK ORDER S)	OPERATION OF PLANT (SQUARE FEET)	
		5.03	5A.04	5.04	6.00	7.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00560	PURCHASING					5.01
5.02	00570	ADMITTING					5.02
5.03	00580	PATIENT ACCOUNTS	279,653,940				5.03
5.04	00590	OTHER A&G	0	-15,317,143	83,545,892		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	497,208	2,170	6.00
7.00	00700	OPERATION OF PLANT	0	0	4,772,329	0	99,469 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	341,231	0	2,922 8.00
9.00	00900	HOUSEKEEPING	0	0	1,982,153	0	2,896 9.00
10.00	01000	DIETARY	0	0	1,635,735	0	10,618 10.00
11.00	01100	CAFETERIA	0	0	295,737	0	4,715 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,627,541	0	1,328 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	0	541,241	0	2,407 16.00
17.00	01700	SOCIAL SERVICE	0	0	2,465,918	0	1,750 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0 20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	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	128,562,144	0	34,384,653	1,847	47,983 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,374,304	0	1,018,859	0	2,598 50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,535,055	0	1,947,259	2	4,506 54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0 56.00
60.00	06000	LABORATORY	10,939,725	0	1,827,561	0	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	58,807,160	0	11,461,953	316	3,411 65.00
66.00	06600	PHYSICAL THERAPY	4,141,184	0	1,807,416	5	1,703 66.00
67.00	06700	OCCUPATIONAL THERAPY	3,445,423	0	1,014,886	0	1,122 67.00
68.00	06800	SPEECH PATHOLOGY	2,611,329	0	676,809	0	999 68.00
68.01	03550	PSYCHOLOGY	0	0	0	0	0 68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,882,538	0	4,713,730	0	0 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,269,707	0	7,265,350	0	4,513 73.00
74.00	07400	RENAL DIALYSIS	9,313,013	0	2,681,240	0	310 74.00
75.01	03630	ULTRASOUND	772,358	0	163,503	0	288 75.01
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							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	279,653,940	-15,317,143	83,122,312	2,170	94,069 118.00
NONREIMBURSABLE COST CENTERS							
190.01	19002	IDLE SPACE	0	0	127,944	0	4,958 190.01
194.00	07950	PSYCHOLOGY	0	0	295,636	0	442 194.00
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	865,968		15,317,143	588,365	5,647,278 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.003097		0.183338	271.135945	56.774251 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	46,850		3,173,286	112,104	742,507 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000168		0.037983	51.660829	7.464708 205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-2010

Period:
From 06/01/2020
To 05/31/2021

Worksheet B-1

Date/Time Prepared:

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Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	
		8.00	9.00	10.00	11.00	12.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00560	PURCHASING					5.01
5.02	00570	ADMITTING					5.02
5.03	00580	PATIENT ACCOUNTS					5.03
5.04	00590	OTHER A&G					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	257,648				8.00
9.00	00900	HOUSEKEEPING	0	93,651			9.00
10.00	01000	DIETARY	0	10,618	87,167		10.00
11.00	01100	CAFETERIA	0	4,715	0	55,712	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,328	0	1,387	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	2,407	0	523	16.00
17.00	01700	SOCIAL SERVICE	0	1,750	0	2,188	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	257,648	47,983	87,167	33,414	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	2,598	0	561	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,506	0	1,005	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	341	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	3,411	0	10,942	65.00
66.00	06600	PHYSICAL THERAPY	0	1,703	0	1,792	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,122	0	838	67.00
68.00	06800	SPEECH PATHOLOGY	0	999	0	607	68.00
68.01	03550	PSYCHOLOGY	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,513	0	1,733	73.00
74.00	07400	RENAL DIALYSIS	0	310	0	0	74.00
75.01	03630	ULTRASOUND	0	288	0	78	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	257,648	88,251	87,167	55,409	118.00
NONREIMBURSABLE COST CENTERS							
190.01	19002	IDLE SPACE	0	4,958	0	0	190.01
194.00	07950	PSYCHOLOGY	0	442	0	303	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	569,686	2,509,975	2,823,033	744,016	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.211102	26.801369	32.386488	13.354681	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	118,464	200,414	529,107	192,283	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.459790	2.140009	6.070038	3.451375	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: 14-2010

Period:
From 06/01/2020
To 05/31/2021

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			NURSING ADMINISTRATION (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	SOCIAL SERVICE (PATIENT DA YS)	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	PATIENT ACCOUNTS						5.03
5.04	00590	OTHER A&G						5.04
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	33,975					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0				14.00
15.00	01500	PHARMACY	0	0	0			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	279,653,940		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	58,302	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	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	33,414	0	0	128,562,144	58,302	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	561	0	0	1,374,304	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	4,535,055	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	10,939,725	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	58,807,160	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,141,184	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,445,423	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,611,329	0	68.00
68.01	03550	PSYCHOLOGY	0	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	20,882,538	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	34,269,707	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	9,313,013	0	74.00
75.01	03630	ULTRASOUND	0	0	0	772,358	0	75.01
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								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,975	0	0	279,653,940	58,302	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19002	IDLE SPACE	0	0	0	0	0	190.01
194.00	07950	PSYCHOLOGY	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,055,442	0	0	848,622	3,093,491	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	60.498661	0.000000	0.000000	0.003035	53.059775	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	117,272	0	0	116,067	170,173	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.451714	0.000000	0.000000	0.000415	2.918819	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: 14-2010

Period:
From 06/01/2020
To 05/31/2021

Worksheet B-1

Date/Time Prepared:
10/26/2021 10:25 am

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS		PARAMED ED PRGM (ASSIGNED TIME)	
				SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
				19.00	20.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00560	PURCHASING					5.01
5.02	00570	ADMITTING					5.02
5.03	00580	PATIENT ACCOUNTS					5.03
5.04	00590	OTHER A&G					5.04
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	0				19.00
20.00	02000	NURSING SCHOOL		0			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	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
68.01	03550	PSYCHOLOGY	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.01	03630	ULTRASOUND	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS							
190.01	19002	IDLE SPACE	0	0	0	0	190.01
194.00	07950	PSYCHOLOGY	0	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	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		0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-2010

Period:
From 06/01/2020
To 05/31/2021Worksheet C
Part I
Date/Time Prepared:
10/26/2021 10:25 am

				Title XVIII	Hospital	PPS		
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE		Total Costs
						Disallowance		
			1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	54,543,674		54,543,674	0	54,543,674	30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,468,388		1,468,388	0	1,468,388	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,708,585		2,708,585	0	2,708,585	54.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
60.00	06000	LABORATORY	2,200,378		2,200,378	0	2,200,378	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	14,258,727	0	14,258,727	0	14,258,727	65.00
66.00	06600	PHYSICAL THERAPY	2,318,970	0	2,318,970	0	2,318,970	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,316,373	0	1,316,373	0	1,316,373	67.00
68.00	06800	SPEECH PATHOLOGY	900,417	0	900,417	0	900,417	68.00
68.01	03550	PSYCHOLOGY	0	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,641,315		5,641,315	0	5,641,315	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,101,695		9,101,695	0	9,101,695	73.00
74.00	07400	RENAL DIALYSIS	3,226,986		3,226,986	0	3,226,986	74.00
75.01	03630	ULTRASOUND	220,935		220,935	0	220,935	75.01
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Subtotal (see instructions)	97,906,443	0	97,906,443	0	97,906,443	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	97,906,443	0	97,906,443	0	97,906,443	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-2010

Period:
From 06/01/2020
To 05/31/2021Worksheet C
Part I
Date/Time Prepared:
10/26/2021 10:25 am

			Title XVIII		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	128,562,144		128,562,144		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,374,304	0	1,374,304	1.068459	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,313,969	221,086	4,535,055	0.597255	0.000000
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000
60.00	06000	LABORATORY	10,776,182	163,543	10,939,725	0.201137	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000
65.00	06500	RESPIRATORY THERAPY	52,855,222	5,951,938	58,807,160	0.242466	0.000000
66.00	06600	PHYSICAL THERAPY	4,132,471	8,713	4,141,184	0.559978	0.000000
67.00	06700	OCCUPATIONAL THERAPY	3,439,867	5,556	3,445,423	0.382064	0.000000
68.00	06800	SPEECH PATHOLOGY	2,601,255	10,074	2,611,329	0.344812	0.000000
68.01	03550	PSYCHOLOGY	0	0	0	0.000000	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,882,538	0	20,882,538	0.270145	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	34,269,707	0	34,269,707	0.265590	0.000000
74.00	07400	RENAL DIALYSIS	8,284,311	1,028,702	9,313,013	0.346503	0.000000
75.01	03630	ULTRASOUND	752,837	19,521	772,358	0.286053	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000
200.00		Subtotal (see instructions)	272,244,807	7,409,133	279,653,940		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	272,244,807	7,409,133	279,653,940		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-2010

Period:
From 06/01/2020
To 05/31/2021Worksheet C
Part I
Date/Time Prepared:
10/26/2021 10:25 am

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1.068459			50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.597255			54.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
60.00	06000	LABORATORY	0.201137			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.242466			65.00
66.00	06600	PHYSICAL THERAPY	0.559978			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.382064			67.00
68.00	06800	SPEECH PATHOLOGY	0.344812			68.00
68.01	03550	PSYCHOLOGY	0.000000			68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.270145			71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.265590			73.00
74.00	07400	RENAL DIALYSIS	0.346503			74.00
75.01	03630	ULTRASOUND	0.286053			75.01
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						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-2010

Period:
From 06/01/2020
To 05/31/2021Worksheet D
Part I
Date/Time Prepared:
10/26/2021 10:25 am

Cost Center Description		Title XVIII		Hospital	PPS			
		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	6,038,623	0	6,038,623	58,302	103.57	30.00	
200.00	Total (lines 30 through 199)	6,038,623		6,038,623	58,302		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	18,783	1,945,355					30.00
200.00	Total (lines 30 through 199)	18,783	1,945,355					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-2010

Period:
From 06/01/2020
To 05/31/2021Worksheet D
Part II
Date/Time Prepared:
10/26/2021 10:25 am

Cost Center Description			Title XVIII		Hospital	PPS		
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	203,366	1,374,304	0.147977	342,152	50,631	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	740,452	4,535,055	0.163273	1,529,111	249,663	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
60.00	06000	LABORATORY	93,308	10,939,725	0.008529	3,700,892	31,565	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	915,508	58,807,160	0.015568	18,700,840	291,135	65.00
66.00	06600	PHYSICAL THERAPY	161,129	4,141,184	0.038909	1,269,463	49,394	66.00
67.00	06700	OCCUPATIONAL THERAPY	85,918	3,445,423	0.024937	1,094,621	27,297	67.00
68.00	06800	SPEECH PATHOLOGY	67,788	2,611,329	0.025959	891,772	23,150	68.00
68.01	03550	PSYCHOLOGY	0	0	0.000000	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	250,851	20,882,538	0.012012	6,885,582	82,710	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	608,655	34,269,707	0.017761	11,560,333	205,323	73.00
74.00	07400	RENAL DIALYSIS	122,447	9,313,013	0.013148	3,058,862	40,218	74.00
75.01	03630	ULTRASOUND	41,237	772,358	0.053391	202,599	10,817	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	3,290,659	151,091,796		49,236,227	1,061,903	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-2010		Period: From 06/01/2020 To 05/31/2021		Worksheet D Part III Date/Time Prepared: 10/26/2021 10:25 am		
					Title XVIII		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00	
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	58,302	0.00	18,783		30.00	
200.00		Total (lines 30 through 199)			0	58,302		18,783		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
200.00		Total (lines 30 through 199)		0							200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-2010

Period:
From 06/01/2020
To 05/31/2021Worksheet D
Part IV
Date/Time Prepared:
10/26/2021 10:25 am

Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
68.01	03550	PSYCHOLOGY	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.01	03630	ULTRASOUND	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-2010

Period:
From 06/01/2020
To 05/31/2021Worksheet D
Part IV
Date/Time Prepared:
10/26/2021 10:25 am

				Title XVIII		Hospital	PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	1,374,304	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	4,535,055	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	10,939,725	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	58,807,160	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,141,184	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,445,423	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,611,329	0.000000	68.00
68.01	03550	PSYCHOLOGY	0	0	0	0	0.000000	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	20,882,538	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	34,269,707	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	9,313,013	0.000000	74.00
75.01	03630	ULTRASOUND	0	0	0	772,358	0.000000	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	151,091,796		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-2010

Period:
From 06/01/2020
To 05/31/2021Worksheet D
Part IV
Date/Time Prepared:
10/26/2021 10:25 am

				Title XVIII		Hospital		PPS		
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
				9.00	10.00	11.00	12.00	13.00		
	ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	342,152	0	0	0	0	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,529,111	0	221,086	0	0	54.00	
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	0	56.00	
60.00	06000	LABORATORY	0.000000	3,700,892	0	163,543	0	0	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	0.000000	18,700,840	0	5,951,938	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	1,269,463	0	8,713	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,094,621	0	5,556	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	891,772	0	10,074	0	0	68.00	
68.01	03550	PSYCHOLOGY	0.000000	0	0	0	0	0	68.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	6,885,582	0	0	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	11,560,333	0	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0.000000	3,058,862	0	1,028,702	0	0	74.00	
75.01	03630	ULTRASOUND	0.000000	202,599	0	19,521	0	0	75.01	
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	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										
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00	
200.00		Total (lines 50 through 199)		49,236,227	0	7,409,133	0	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-2010

Period:
From 06/01/2020
To 05/31/2021Worksheet D
Part V
Date/Time Prepared:
10/26/2021 10:25 am

				Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	1.068459	0	0	0	0	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.597255	221,086	0	0	132,045	54.00	
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00	
60.00	06000	LABORATORY	0.201137	163,543	0	0	32,895	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	0.242466	5,951,938	0	0	1,443,143	65.00	
66.00	06600	PHYSICAL THERAPY	0.559978	8,713	0	0	4,879	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.382064	5,556	0	0	2,123	67.00	
68.00	06800	SPEECH PATHOLOGY	0.344812	10,074	0	0	3,474	68.00	
68.01	03550	PSYCHOLOGY	0.000000	0	0	0	0	68.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.270145	0	0	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.265590	0	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0.346503	1,028,702	0	0	356,448	74.00	
75.01	03630	ULTRASOUND	0.286053	19,521	0	0	5,584	75.01	
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									
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00	
200.00		Subtotal (see instructions)		7,409,133	0	0	1,980,591	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		7,409,133	0	0	1,980,591	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-2010

Period:
From 06/01/2020
To 05/31/2021Worksheet D
Part V
Date/Time Prepared:
10/26/2021 10:25 am

				Title XVIII	Hospital	PPS
	Cost Center Description	Costs				
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		6.00	7.00			
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
68.01	03550	PSYCHOLOGY	0	0		68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.01	03630	ULTRASOUND	0	0		75.01
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					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-2010

Period:
From 06/01/2020
To 05/31/2021

Worksheet D-1

Date/Time Prepared:

10/26/2021 10:25 am

Cost Center Description		Title XVIII	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		58,302	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		58,302	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)		58,302	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)		18,783	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		54,543,674	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)		54,543,674	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)		54,543,674	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)		935.54	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		17,572,248	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)		17,572,248	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-2010

Period:
From 06/01/2020
To 05/31/2021

Worksheet D-1

Date/Time Prepared:
10/26/2021 10:25 am

Cost Center Description		Title XVIII			Hospital	PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)					14,042,402	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					31,614,650	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)					1,945,355	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,061,903	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					3,007,258	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					28,607,392	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-2010

Period:
From 06/01/2020
To 05/31/2021

Worksheet D-1

Date/Time Prepared:
10/26/2021 10:25 am

Cost Center Description		Title XVIII		Hospital	PPS	
		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	6,038,623	54,543,674	0.110712	0	0
91.00	Nursing School cost	0	54,543,674	0.000000	0	0
92.00	Allied health cost	0	54,543,674	0.000000	0	0
93.00	All other Medical Education	0	54,543,674	0.000000	0	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-2010	Period: From 06/01/2020 To 05/31/2021	Worksheet D-3 Date/Time Prepared: 10/26/2021 10:25 am	
		Title XVIII	Hospital	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		41,310,562		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	1.068459	342,152	365,575	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.597255	1,529,111	913,269	54.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
60.00	06000 LABORATORY	0.201137	3,700,892	744,386	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.242466	18,700,840	4,534,318	65.00
66.00	06600 PHYSICAL THERAPY	0.559978	1,269,463	710,871	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.382064	1,094,621	418,215	67.00
68.00	06800 SPEECH PATHOLOGY	0.344812	891,772	307,494	68.00
68.01	03550 PSYCHOLOGY	0.000000	0	0	68.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.270145	6,885,582	1,860,106	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.265590	11,560,333	3,070,309	73.00
74.00	07400 RENAL DIALYSIS	0.346503	3,058,862	1,059,905	74.00
75.01	03630 ULTRASOUND	0.286053	202,599	57,954	75.01
76.97	07697 CARDIAC REHABILITATION	0.000000	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					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		49,236,227	14,042,402	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		49,236,227		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-2010	Period: From 06/01/2020 To 05/31/2021	Worksheet E Part B Date/Time Prepared: 10/26/2021 10:25 am
		Title XVIII	Hospital	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		1,980,591	2.00
3.00	OPPS payments		1,538,344	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)		0.939	5.00
6.00	Line 2 times line 5		1,859,775	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		82.72	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)		0	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)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		1,538,344	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)		307,668	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)		1,230,676	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)		1,230,676	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,230,676	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)		1,230,676	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)		1,230,676	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		1,230,676	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)		0	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-2010

Period:
From 06/01/2020
To 05/31/2021Worksheet E-1
Part I
Date/Time Prepared:
10/26/2021 10:25 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		25,729,663		1,230,676	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	02/04/2021	1,763,199		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)		-1,763,199		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)		23,966,464		1,230,676	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		1,281,385		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		25,247,849		1,230,676	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-2010	Period: From 06/01/2020 To 05/31/2021	Worksheet E-3 Part IV Date/Time Prepared: 10/26/2021 10:25 am
		Title XVIII	Hospital	PPS
		1.00		
PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)		25,048,461	1.00
1.01	Full standard payment amount		20,994,391	1.01
1.02	Short stay outlier standard payment amount		4,054,070	1.02
1.03	Site neutral payment amount - Cost		0	1.03
1.04	Site neutral payment amount - IPPS comparable		0	1.04
2.00	Outlier Payments		3,792,177	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)		28,840,638	3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)		0	4.00
5.00	Organ acquisition (DO NOT USE THIS LINE)		0	5.00
6.00	Cost of physicians' services in a teaching hospital (see instructions)		0	6.00
7.00	Subtotal (see instructions)		28,840,638	7.00
8.00	Primary payer payments		0	8.00
9.00	Subtotal (line 7 less line 8).		28,840,638	9.00
10.00	Deductibles		34,204	10.00
11.00	Subtotal (line 9 minus line 10)		28,806,434	11.00
12.00	Coinsurance		4,757,702	12.00
13.00	Subtotal (line 11 minus line 12)		24,048,732	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		1,844,796	14.00
15.00	Adjusted reimbursable bad debts (see instructions)		1,199,117	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,509,547	16.00
17.00	Subtotal (sum of lines 13 and 15)		25,247,849	17.00
18.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	18.00
19.00	Other pass through costs (see instructions)		0	19.00
20.00	Outlier payments reconciliation		0	20.00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	21.00
21.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	21.50
21.99	Demonstration payment adjustment amount before sequestration		0	21.99
22.00	Total amount payable to the provider (see instructions)		25,247,849	22.00
22.01	Sequestration adjustment (see instructions)		0	22.01
22.02	Demonstration payment adjustment amount after sequestration		0	22.02
23.00	Interim payments		23,966,464	23.00
24.00	Tentative settlement (for contractor use only)		0	24.00
25.00	Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24)		1,281,385	25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	26.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions)		3,792,177	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money (see instructions)		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

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

Provider CCN: 14-2010

Period:
From 06/01/2020
To 05/31/2021

Worksheet G

Date/Time Prepared:
10/26/2021 10:25 am

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	1,919,279	0	0	0	1.00
2.00 Temporary investments	3,328	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	27,417,604	0	0	0	4.00
5.00 Other receivable	1,416,471	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-4,602,747	0	0	0	6.00
7.00 Inventory	1,030,458	0	0	0	7.00
8.00 Prepaid expenses	2,415,839	0	0	0	8.00
9.00 Other current assets	4,205,807	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)	33,806,039	0	0	0	11.00
FIXED ASSETS					
12.00 Land	0	0	0	0	12.00
13.00 Land improvements	0	0	0	0	13.00
14.00 Accumulated depreciation	0	0	0	0	14.00
15.00 Buildings	39,853,426	0	0	0	15.00
16.00 Accumulated depreciation	-9,154,825	0	0	0	16.00
17.00 Leasehold improvements	15,493,931	0	0	0	17.00
18.00 Accumulated depreciation	-2,637,575	0	0	0	18.00
19.00 Fixed equipment	5,706,966	0	0	0	19.00
20.00 Accumulated depreciation	-5,218,896	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	29,193,929	0	0	0	23.00
24.00 Accumulated depreciation	-18,882,382	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)	54,354,574	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	49,446,734	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	6,518,484	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	55,965,218	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	144,125,831	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	655,383	0	0	0	37.00
38.00 Salaries, wages, and fees payable	7,260,718	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	971,619	0	0	0	43.00
44.00 Other current liabilities	21,010,781	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	29,898,501	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	34,379,020	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	10,825,211	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	45,204,231	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	75,102,732	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	69,023,099	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	69,023,099	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	144,125,831	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-2010

Period:
From 06/01/2020
To 05/31/2021

Worksheet G-1

Date/Time Prepared:
10/26/2021 10:25 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		59,940,793		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		19,661,952				2.00
3.00	Total (sum of line 1 and line 2)		79,602,745		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	ADVOCATE CAPITAL CONTRIBUTIONS	0		0		0	5.00
6.00	CHANGE IN TEMP RESTRICTED CONTRIBUT	0		0		0	6.00
7.00	UNREALIZED GAINS/(LOSSES), ON FIXED	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)		79,602,745		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	UNREALIZED LOSS ON INVESTMENT	10,579,646		0		0	13.00
14.00	PARTNERSHIP DISTRIBUTIONS	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)		10,579,646		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		69,023,099		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	ADVOCATE CAPITAL CONTRIBUTIONS		0				5.00
6.00	CHANGE IN TEMP RESTRICTED CONTRIBUT		0				6.00
7.00	UNREALIZED GAINS/(LOSSES), ON FIXED		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	UNREALIZED LOSS ON INVESTMENT		0				13.00
14.00	PARTNERSHIP DISTRIBUTIONS		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: 14-2010

Period:
From 06/01/2020
To 05/31/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
10/26/2021 10:25 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	128,562,144		128,562,144	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	128,562,144		128,562,144	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	128,562,144		128,562,144	17.00
18.00	Ancillary services	143,682,662	7,409,134	151,091,796	18.00
19.00	Outpatient services	0	0	0	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
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	0	3,490,720	3,490,720	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	272,244,806	10,899,854	283,144,660	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		112,160,417		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	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)		112,160,417		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-2010

Period:
From 06/01/2020
To 05/31/2021

Worksheet G-3

Date/Time Prepared:

10/26/2021 10:25 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	283,144,660	1.00
2.00	Less contractual allowances and discounts on patients' accounts	157,323,112	2.00
3.00	Net patient revenues (line 1 minus line 2)	125,821,548	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	112,160,417	4.00
5.00	Net income from service to patients (line 3 minus line 4)	13,661,131	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (OTHER REVENUE)	1,370,695	24.00
24.01	OTHER (GRANT REVENUE)	0	24.01
24.02	OTHER (GAIN ON SALE OF ASSET)	3,786,038	24.02
24.50	COVID-19 PHE Funding	844,088	24.50
25.00	Total other income (sum of lines 6-24)	6,000,821	25.00
26.00	Total (line 5 plus line 25)	19,661,952	26.00
27.00	GAIN ON SALE OF ASSET	0	27.00
27.01	MISCELLANEOUS	0	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	19,661,952	29.00