

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interest payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

OMB NO. 0938-0050

EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN:14-2011	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 11/29/2021 12:20 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 11/29/2021 Time: 12:20 pm
	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 THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT MAY RESULT.

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HOLY FAMILY MEDICAL CENTER (14-2011) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) MICHAEL MULAY

Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER

Title

(Dated when report is electronically signed.)

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	514,060	23,717	0	0	1.00	
2.00	Subprovider - IPF	0	0	0	0	0	2.00	
3.00	Subprovider - IRF	0	0	0	0	0	3.00	
5.00	Swing Bed - SNF	0	0	0	0	0	5.00	
6.00	Swing Bed - NF	0				0	6.00	
200.00	Total	0	514,060	23,717	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 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 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:14-2011		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 12:20 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street:100 NORTH RIVER ROAD, SECOND FLOOR			PO Box:				1.00	
2.00	City: DES PLAINES			State: IL		Zip Code:60016		County: COOK	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			HOLY FAMILY MEDICAL CENTER	142011	16974	2	03/01/2006	N
4.00	Subprovider - IPF							P	P
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2020	06/30/2021	20.00
21.00	Type of Control (see instructions)						1		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.					0	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN:14-2011

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/29/2021 12:20 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN:14-2011		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 12:20 pm	
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N					60.00
		Y/N	IME	Direct GME	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)				0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00		61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00		61.20
						1.00	
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
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
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" N for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)						63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN:14-2011

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/29/2021 12:20 pm

			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN:14-2011	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 12:20 pm
			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 1.00	XIX 2.00
Title V and XIX Services				
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	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	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.	Y	Y	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.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
Rural Providers				
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00

Health Financial Systems		HOLY FAMILY MEDICAL CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN:14-2011	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 12:20 pm	
			V	XIX	
			1.00	2.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR N Section §412.113(c). Enter "Y" for yes or "N" for no.				108.00
			Physical	Occupational	
			1.00	2.00	
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	
			3.00		
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.			N	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.			N	116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.			N	117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			2	118.00
			Premiums	Losses	Insurance
			1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:		0	0	1,451,261
			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.			N	120.00
121.00	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.				
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.			Y	121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.			Y	5.06
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.			N	125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00

Health Financial Systems		HOLY FAMILY MEDICAL CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN:14-2011		Period: From 07/01/2020 To 06/30/2021	
				Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 12:20 pm	
		1.00		2.00	
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		14H082 140.00	
		1.00		2.00	
		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: PRESENCE CARE TRASFORMATION COM	Contractor's Name:NGS		Contractor's Number:00131 141.00	
142.00	Street:200 S. WACKER DRIVE	PO Box:		142.00	
143.00	City: CHICAGO	State: IL		Zip Code: 60606 143.00	
		1.00		2.00	
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		2.00	
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	
		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	N	N	N	N 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	N 161.00
		1.00		2.00	
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	
		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)			0.00 166.00	
		1.00		2.00	
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:14-2011

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/29/2021 12:20 pm

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

Health Financial Systems		HOLY FAMILY MEDICAL CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN:14-2011	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/29/2021 12:20 pm	
			Y/N 1.00	Date 2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		N		3.00
			Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		N		5.00
			Y/N 1.00	Legal Oper. 2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the 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 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.				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	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	11/13/2020	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N	N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N	N	19.00

Health Financial Systems		HOLY FAMILY MEDICAL CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN:14-2011		Period: From 07/01/2020 To 06/30/2021	
		Worksheet S-2 Part II Date/Time Prepared: 11/29/2021 12:20 pm			
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N	N		20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N			22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N			23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?	Y			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y			37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N			40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICK	GILLILAND		41.00
42.00	Enter the employer/company name of the cost report preparer	PRESENCE HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	8478133718	PATRICK.GILLILAND@AMITAHEALTH.ORG		43.00

Health Financial Systems		HOLY FAMILY MEDICAL CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN:14-2011		Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/29/2021 12:20 pm
		3.00			
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REGIONAL DIRECTOR OF REIMBURSEMENT			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:14-2011

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/29/2021 12:20 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	120	43,800	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)		120	43,800	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,920	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		128	46,720	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)		128				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:14-2011

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/29/2021 12:20 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	12,396	6,168	31,585			1.00
2.00 HMO and other (see instructions)	0	0				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)	12,396	6,168	31,585			7.00
8.00 INTENSIVE CARE UNIT	644	540	2,326			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	13,040	6,708	33,911	0.00	370.32	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)			28			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	370.32	27.00
28.00 Observation Bed Days		0	0			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00
33.01 LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN:14-2011

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/29/2021 12:20 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	410	182	1,411	1.00
2.00 HMO and other (see instructions)			0	0		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	410	182	1,411	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			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN:14-2011

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

Worksheet A

Date/Time Prepared:
11/29/2021 12:20 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	2,848,299	2,848,299	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	1,828,282	1,828,282	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	430,391	4,995,948	5,426,339	-1,538	5,424,801	4.00
5.01	00540	NONPATIENT TELEPHONES	0	57,777	57,777	0	57,777	5.01
5.02	00550	DATA PROCESSING	0	0	0	0	0	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	0	0	0	0	5.03
5.04	00570	ADMITTING	0	0	0	0	0	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.05
5.06	00590	ADMINISTRATIVE & GENERAL	3,439,096	27,008,785	30,447,881	-915,717	29,532,164	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	758,696	758,696	-1,428	757,268	6.00
7.00	00700	OPERATION OF PLANT	370,574	1,708,560	2,079,134	-353,344	1,725,790	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	291,253	291,253	-77	291,176	8.00
9.00	00900	HOUSEKEEPING	0	1,593,203	1,593,203	-21,987	1,571,216	9.00
10.00	01000	DIETARY	0	1,776,031	1,776,031	-1,243,642	532,389	10.00
11.00	01100	CAFETERIA	0	0	0	1,244,122	1,244,122	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	738,471	404,018	1,142,489	-225,079	917,410	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	77,789	795,683	873,472	-531,729	341,743	14.00
15.00	01500	PHARMACY	942,580	3,522,637	4,465,217	-3,352,904	1,112,313	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	548	548	-548	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
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
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,051,632	6,942,287	19,993,919	-2,908,117	17,085,802	30.00
31.00	03100	INTENSIVE CARE UNIT	1,703,497	2,552,288	4,255,785	-414,867	3,840,918	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	728,589	582,716	1,311,305	-410,045	901,260	50.00
53.00	05300	ANESTHESIOLOGY	0	423,110	423,110	-4,420	418,690	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	498,020	532,290	1,030,310	-293,123	737,187	54.00
56.00	05600	RADIOISOTOPE	49,107	28,044	77,151	-19,714	57,437	56.00
57.00	05700	CT SCAN	124,355	20,043	144,398	-7,779	136,619	57.00
57.01	03630	ULTRA SOUND	121,255	32,097	153,352	-22,292	131,060	57.01
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	2,898,698	2,898,698	-226,342	2,672,356	60.00
65.00	06500	RESPIRATORY THERAPY	3,390,539	868,297	4,258,836	-532,267	3,726,569	65.00
66.00	06600	PHYSICAL THERAPY	2,017,018	181,967	2,198,985	-24,009	2,174,976	66.00
69.00	06900	ELECTROCARDIOLOGY	20,119	-2,615	17,504	4,061	21,565	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	128,586	19,807	148,393	-7,619	140,774	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,814,434	3,814,434	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	499,128	499,128	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,431,742	3,431,742	73.00
74.00	07400	RENAL DIALYSIS	628,790	317,782	946,572	-136,237	810,335	74.00
76.00	03950	SUBSTANCE ABUSE	278,219	221,396	499,615	-124,466	375,149	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	88,011	597,989	686,000	-569,726	116,274	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1,505	1,505	-1,505	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	79,778	36,395	116,173	-23,281	92,892	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		1,296,266	1,296,266	-1,296,266	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,906,416	60,463,501	89,369,917	0	89,369,917	118.00
NONREIMBURSABLE COST CENTERS								
200.00		TOTAL (SUM OF LINES 118 through 199)	28,906,416	60,463,501	89,369,917	0	89,369,917	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN:14-2011

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

Worksheet A

Date/Time Prepared:
11/29/2021 12:20 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,836,344	1,011,955	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,957,060	4,785,342	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,429,694	2,995,107	4.00
5.01	00540	NONPATIENT TELEPHONES	66,134	123,911	5.01
5.02	00550	DATA PROCESSING	0	0	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	0	5.03
5.04	00570	ADMITTING	0	0	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	5.05
5.06	00590	ADMINISTRATIVE & GENERAL	-9,014,039	20,518,125	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	757,268	6.00
7.00	00700	OPERATION OF PLANT	2,075,082	3,800,872	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,109	297,285	8.00
9.00	00900	HOUSEKEEPING	0	1,571,216	9.00
10.00	01000	DIETARY	-5,985	526,404	10.00
11.00	01100	CAFETERIA	-132,780	1,111,342	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	65,886	983,296	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-43,920	297,823	14.00
15.00	01500	PHARMACY	21,380	1,133,693	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	25,653	25,653	16.00
17.00	01700	SOCIAL SERVICE	452,036	452,036	17.00
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
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-649,496	16,436,306	30.00
31.00	03100	INTENSIVE CARE UNIT	328,345	4,169,263	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	901,260	50.00
53.00	05300	ANESTHESIOLOGY	-418,527	163	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-3,190	733,997	54.00
56.00	05600	RADIOISOTOPE	0	57,437	56.00
57.00	05700	CT SCAN	0	136,619	57.00
57.01	03630	ULTRA SOUND	0	131,060	57.01
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	-1,694	2,670,662	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,726,569	65.00
66.00	06600	PHYSICAL THERAPY	0	2,174,976	66.00
69.00	06900	ELECTROCARDIOLOGY	0	21,565	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	140,774	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,814,434	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	499,128	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,431,742	73.00
74.00	07400	RENAL DIALYSIS	0	810,335	74.00
76.00	03950	SUBSTANCE ABUSE	0	375,149	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	-3,865	112,409	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	92,892	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,541,849	80,828,068	118.00
NONREIMBURSABLE COST CENTERS					
200.00		TOTAL (SUM OF LINES 118 through 199)	-8,541,849	80,828,068	200.00

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,296,266		1.00
	TOTALS		0	1,296,266		
	B - CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,552,033		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	590,469		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
	TOTALS		0	2,142,502		
	C - RECLASS DIETARY COSTS					
1.00	CAFETERIA	11.00	0	1,244,122		1.00
	TOTALS		0	1,244,122		
	D - RECLASS SUPPLY COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	3,814,434		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	499,128		2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,431,742		3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	6,424		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	301,189		5.00
6.00	ELECTROCARDIOLOGY	69.00	0	7,061		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
	TOTALS		0	8,059,978		
	E - MISC					
1.00	DIETARY	10.00	0	1,505		1.00
	TOTALS		0	1,505		
	G - RECLASS RENTAL COSTS					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,237,813		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	1,237,813		
	H - RECLASS SUBSTANCE ABUSE					
1.00	SUBSTANCE ABUSE	76.00	34,358	2,495		1.00
	TOTALS		34,358	2,495		
500.00	Grand Total: Increases		34,358	13,984,681		500.00

RECLASSIFICATIONS

Provider CCN:14-2011

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

Worksheet A-6

Date/Time Prepared:
11/29/2021 12:20 pm

	Decreases							
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
	A - INTEREST							
1.00	INTEREST EXPENSE	113.00	0	1,296,266	11		1.00	
	TOTALS		0	1,296,266				
	B - CAPITAL COSTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	922,141	9		1.00	
2.00	MAINTENANCE & REPAIRS	6.00	0	1,104	9		2.00	
3.00	OPERATION OF PLANT	7.00	0	350,874	0		3.00	
4.00	HOUSEKEEPING	9.00	0	4,015	0		4.00	
5.00	DIETARY	10.00	0	1,025	0		5.00	
6.00	NURSING ADMINISTRATION	13.00	0	179,162	0		6.00	
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	11,098	0		7.00	
8.00	PHARMACY	15.00	0	49,743	0		8.00	
9.00	ADULTS & PEDIATRICS	30.00	0	28,568	0		9.00	
10.00	INTENSIVE CARE UNIT	31.00	0	137,493	0		10.00	
11.00	OPERATING ROOM	50.00	0	77,094	0		11.00	
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	100,623	0		12.00	
13.00	ULTRA SOUND	57.01	0	20,972	0		13.00	
14.00	LABORATORY	60.00	0	59,317	0		14.00	
15.00	RESPIRATORY THERAPY	65.00	0	12,146	0		15.00	
16.00	PHYSICAL THERAPY	66.00	0	2,071	0		16.00	
17.00	ELECTROCARDIOLOGY	69.00	0	3,000	0		17.00	
18.00	ELECTROENCEPHALOGRAPHY	70.00	0	517	0		18.00	
19.00	RENAL DIALYSIS	74.00	0	17,416	0		19.00	
20.00	SUBSTANCE ABUSE	76.00	0	142,077	0		20.00	
21.00	WOMENS DIAGNOSTIC CENTER	90.02	0	22,046	0		21.00	
	TOTALS		0	2,142,502				
	C - RECLASS DIETARY COSTS							
1.00	DIETARY	10.00	0	1,244,122	0		1.00	
	TOTALS		0	1,244,122				
	D - RECLASS SUPPLY COSTS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,538	0		1.00	
2.00	MAINTENANCE & REPAIRS	6.00	0	324	0		2.00	
3.00	OPERATION OF PLANT	7.00	0	2,470	0		3.00	
4.00	LAUNDRY & LINEN SERVICE	8.00	0	77	0		4.00	
5.00	HOUSEKEEPING	9.00	0	17,972	0		5.00	
6.00	NURSING ADMINISTRATION	13.00	0	45,917	0		6.00	
7.00	PHARMACY	15.00	0	3,268,751	0		7.00	
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	548	0		8.00	
9.00	ADULTS & PEDIATRICS	30.00	0	2,842,696	0		9.00	
10.00	INTENSIVE CARE UNIT	31.00	0	277,374	0		10.00	
11.00	OPERATING ROOM	50.00	0	332,951	0		11.00	
12.00	ANESTHESIOLOGY	53.00	0	4,420	0		12.00	
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	192,500	0		13.00	
14.00	RADIOISOTOPE	56.00	0	19,714	0		14.00	
15.00	CT SCAN	57.00	0	7,779	0		15.00	
16.00	ULTRA SOUND	57.01	0	1,320	0		16.00	
17.00	LABORATORY	60.00	0	167,025	0		17.00	
18.00	RESPIRATORY THERAPY	65.00	0	418,024	0		18.00	
19.00	PHYSICAL THERAPY	66.00	0	21,938	0		19.00	
20.00	ELECTROENCEPHALOGRAPHY	70.00	0	7,102	0		20.00	
21.00	RENAL DIALYSIS	74.00	0	115,827	0		21.00	
22.00	SUBSTANCE ABUSE	76.00	0	19,242	0		22.00	
23.00	HYPERBARIC OXYGEN THERAPY	76.98	0	293,234	0		23.00	
24.00	WOMENS DIAGNOSTIC CENTER	90.02	0	1,235	0		24.00	
	TOTALS		0	8,059,978				
	E - MISC							
1.00	CLINIC	90.00	0	1,505	0		1.00	
	TOTALS		0	1,505				
	G - RECLASS RENTAL COSTS							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	821,820	10		1.00	
2.00	PHARMACY	15.00	0	34,410	0		2.00	
3.00	RESPIRATORY THERAPY	65.00	0	102,097	0		3.00	
4.00	RENAL DIALYSIS	74.00	0	2,994	0		4.00	
5.00	HYPERBARIC OXYGEN THERAPY	76.98	0	276,492	0		5.00	
	TOTALS		0	1,237,813				
	H - RECLASS SUBSTANCE ABUSE							
1.00	ADULTS & PEDIATRICS	30.00	34,358	2,495	0		1.00	
	TOTALS		34,358	2,495				
500.00	Grand Total: Decreases		34,358	13,984,681			500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN:14-2011

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part I
Date/Time Prepared:
11/29/2021 12:20 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	6,320,000	0	0	0	0	1.00
2.00	Land Improvements	397,500	89,351	0	89,351	0	2.00
3.00	Buildings and Fixtures	25,521,336	0	0	0	1,711,030	3.00
4.00	Building Improvements	1,188,040	286,911	0	286,911	0	4.00
5.00	Fixed Equipment	3,873,660	792,502	0	792,502	0	5.00
6.00	Movable Equipment	2,643,638	2,129,044	0	2,129,044	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	39,944,174	3,297,808	0	3,297,808	1,711,030	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	39,944,174	3,297,808	0	3,297,808	1,711,030	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
		PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES					
1.00	Land	6,320,000	0				1.00
2.00	Land Improvements	486,851	0				2.00
3.00	Buildings and Fixtures	23,810,306	0				3.00
4.00	Building Improvements	1,474,951	0				4.00
5.00	Fixed Equipment	4,666,162	0				5.00
6.00	Movable Equipment	4,772,682	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	41,530,952	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	41,530,952	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN:14-2011

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part II
Date/Time Prepared:
11/29/2021 12:20 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN:14-2011

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part III
Date/Time Prepared:
11/29/2021 12:20 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	36,758,270	0	36,758,270	0.885081	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,772,682	0	4,772,682	0.114919	0	2.00
3.00	Total (sum of lines 1-2)	41,530,952	0	41,530,952	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,011,955	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,547,529	1,237,813	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,559,484	1,237,813	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,011,955	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	4,785,342	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	5,797,297	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN:14-2011

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

Worksheet A-8

Date/Time Prepared:
11/29/2021 12:20 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #	Wkst. A-7 Ref.	
				3.00	4.00			
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-1,296,266	CAP REL COSTS-BLDG & FIXT	1.00		11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
3.00	Investment income - other (chapter 2)		0		0.00		0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00		0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00		0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00		0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00		0	7.00
8.00	Television and radio service (chapter 21)		0		0.00		0	8.00
9.00	Parking lot (chapter 21)		0		0.00		0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,997,592				0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00		0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-3,281,408				0	12.00
13.00	Laundry and linen service		0		0.00		0	13.00
14.00	Cafeteria-employees and guests	B	-132,780	CAFETERIA	11.00		0	14.00
15.00	Rental of quarters to employees and others		0		0.00		0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-90	MEDICAL RECORDS & LIBRARY	16.00		0	16.00
17.00	Sale of drugs to other than patients		0		0.00		0	17.00
18.00	Sale of medical records and abstracts		0		0.00		0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00		0	19.00
20.00	Vending machines	B	-5,985	DIETARY	10.00		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	A	-556,764	CAP REL COSTS-BLDG & FIXT	1.00		9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	399,243	CAP REL COSTS-MVBLE EQUIP	2.00		9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00			28.00
29.00	Physicians' assistant		0		0.00		0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00			30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00			30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00			31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00		0	32.00
33.00	OFFSET SUBSTANCE ABUSE REVENUE		0		0.00		0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN:14-2011

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

Worksheet A-8

Date/Time Prepared:
11/29/2021 12:20 pm

Cost Center Description			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #	Wkst. A-7 Ref.
			Basis/Code (2)	Amount		
			1.00	2.00	3.00	4.00
33.01	MISC ADMIN INCOME	B		-65,631	ADMINISTRATIVE & GENERAL	5.06
33.02	RADIOLOGY INCOME	B		-3,190	RADIOLOGY-DIAGNOSTIC	54.00
34.00	OTHER ADJUSTMENTS (SPECIFY) (3)			0		0.00
35.00	OTHER ADJUSTMENTS (SPECIFY) (3)			0		0.00
36.00	OTHER ADJUSTMENTS (SPECIFY) (3)			0		0.00
37.00	OTHER ADJUSTMENTS (SPECIFY) (3)			0		0.00
38.00	OFFSET CHILDCARE INCOME	B		-368,495	EMPLOYEE BENEFITS DEPARTMENT	4.00
39.00	INCOME TAX	A		-3,483	ADMINISTRATIVE & GENERAL	5.06
39.01	BUSINESS DEV & PHYSICIAN RELATIONS	A		-1,229,408	ADMINISTRATIVE & GENERAL	5.06
39.02	OTHER ADJUSTMENTS (SPECIFY) (3)			0		0.00
39.03	OTHER ADJUSTMENTS (SPECIFY) (3)			0		0.00
39.04	OTHER ADJUSTMENTS (SPECIFY) (3)			0		0.00
39.05	OTHER ADJUSTMENTS (SPECIFY) (3)			0		0.00
39.06	OTHER ADJUSTMENTS (SPECIFY) (3)			0		0.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)			-8,541,849		50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN:14-2011

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

Worksheet A-8-1

Date/Time Prepared:
11/29/2021 12:20 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	2.00	CAP REL COSTS-MVBLE EQUIP	IS CAPITAL RELATED COSTS	1,649,949	0 1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	POOLED CAPITAL RELATED BUILD	16,686	0 2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	POOLED CAPITAL RELATED EQUIP	907,868	0 3.00
3.01	5.06	ADMINISTRATIVE & GENERAL	COVID 19 VACCINE	11,529	0 3.01
3.02	5.06	ADMINISTRATIVE & GENERAL	IS SERVICES	3,993,230	14,320,937 3.02
3.03	5.06	ADMINISTRATIVE & GENERAL	CALL CENTER AND CENTRAL SCHE	268,778	0 3.03
3.04	5.06	ADMINISTRATIVE & GENERAL	CLINICAL INFORMATICS	24,434	0 3.04
3.05	5.06	ADMINISTRATIVE & GENERAL	CREDENTIALING	34,034	0 3.05
3.06	5.06	ADMINISTRATIVE & GENERAL	QUALITY MGMT	261,360	0 3.06
3.07	15.00	PHARMACY	PHARMACY ADMIN	21,380	0 3.07
3.08	5.06	ADMINISTRATIVE & GENERAL	REVENUE CYCLE	50,178	0 3.08
3.09	5.06	ADMINISTRATIVE & GENERAL	PT ACCESS	30,107	0 3.09
3.10	5.06	ADMINISTRATIVE & GENERAL	MEDICAL ADMIN	72,867	0 3.10
3.11	5.06	ADMINISTRATIVE & GENERAL	MANAGED CARE	56,723	0 3.11
3.12	13.00	NURSING ADMINISTRATION	NURSING ADMING	65,886	0 3.12
3.13	7.00	OPERATION OF PLANT	FACILITIES	2,075,082	0 3.13
3.14	5.06	ADMINISTRATIVE & GENERAL	SERVICE LINES	195,911	0 3.14
3.15	4.00	EMPLOYEE BENEFITS DEPARTMENT	HUMAN RESOURCES	205,041	2,266,240 3.15
3.16	5.01	NONPATIENT TELEPHONES	TELECOM	66,134	0 3.16
3.17	14.00	CENTRAL SERVICES & SUPPLY	MATERIALS MGMT	-43,920	0 3.17
3.18	16.00	MEDICAL RECORDS & LIBRARY	HIM	25,743	0 3.18
3.19	17.00	SOCIAL SERVICE	CASE MGMT	452,036	0 3.19
3.20	31.00	INTENSIVE CARE UNIT	TELE ICU	328,345	0 3.20
3.21	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY	6,109	0 3.21
3.22	5.06	ADMINISTRATIVE & GENERAL	POOLED A&G	4,131,508	1,606,299 3.22
3.23	60.00	LABORATORY	ALVERNO	2,642,499	2,637,429 3.23
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.			17,549,497	20,830,905 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	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

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

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	B	PRESENCE CARE	100.00	0.00	6.00
7.00	C	ALVERNO LAB	66.67	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or non-financial) specify:			0.00	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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN:14-2011	Period: From 07/01/2020 To 06/30/2021	Worksheet A-8-1 Date/Time Prepared: 11/29/2021 12:20 pm
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	Net Adjustment (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	1,649,949	9		1.00
2.00	16,686	9		2.00
3.00	907,868	9		3.00
3.01	11,529	0		3.01
3.02	-10,327,707	0		3.02
3.03	268,778	0		3.03
3.04	24,434	0		3.04
3.05	34,034	0		3.05
3.06	261,360	0		3.06
3.07	21,380	0		3.07
3.08	50,178	0		3.08
3.09	30,107	0		3.09
3.10	72,867	0		3.10
3.11	56,723	0		3.11
3.12	65,886	0		3.12
3.13	2,075,082	0		3.13
3.14	195,911	0		3.14
3.15	-2,061,199	0		3.15
3.16	66,134	0		3.16
3.17	-43,920	0		3.17
3.18	25,743	0		3.18
3.19	452,036	0		3.19
3.20	328,345	0		3.20
3.21	6,109	0		3.21
3.22	2,525,209	0		3.22
3.23	5,070	0		3.23
4.00	0	0		4.00
5.00	-3,281,408			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 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN:14-2011

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

Worksheet A-8-2

Date/Time Prepared:
11/29/2021 12:20 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	1,176,604	796,896	379,708	211,500	2,534	1.00
2.00	30.00	ADULTS & PEDIATRICS	649,496	649,496	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	418,527	418,527	0	0	0	3.00
4.00	60.00	LABORATORY	21,000	0	21,000	211,500	140	4.00
5.00	76.98	HYPERBARIC OXYGEN THERAPY	12,000	0	12,000	211,500	80	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			2,277,627	1,864,919	412,708		2,754	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	257,664	12,883	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	14,236	712	0	0	0	4.00
5.00	76.98	HYPERBARIC OXYGEN THERAPY	8,135	407	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			280,035	14,002	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	257,664	122,044	918,940		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	649,496		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	418,527		3.00
4.00	60.00	LABORATORY	0	14,236	6,764	6,764		4.00
5.00	76.98	HYPERBARIC OXYGEN THERAPY	0	8,135	3,865	3,865		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	280,035	132,673	1,997,592		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-2011

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/29/2021 12:20 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	5.01
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,011,955	1,011,955			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,785,342		4,785,342		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,995,107	11,536	54,549	3,061,192	4.00
5.01	00540	NONPATIENT TELEPHONES	123,911	0	0	0	5.01
5.02	00550	DATA PROCESSING	0	0	0	0	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	0	0	0	5.03
5.04	00570	ADMITTING	0	0	0	0	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	5.05
5.06	00590	ADMINISTRATIVE & GENERAL	20,518,125	396,130	1,873,220	369,706	5.06
6.00	00600	MAINTENANCE & REPAIRS	757,268	3,998	18,906	0	6.00
7.00	00700	OPERATION OF PLANT	3,800,872	182,037	860,818	39,837	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	297,285	14,832	70,140	0	8.00
9.00	00900	HOUSEKEEPING	1,571,216	10,580	50,032	0	9.00
10.00	01000	DIETARY	526,404	32,298	152,732	0	10.00
11.00	01100	CAFETERIA	1,111,342	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	983,296	8,119	38,392	79,386	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	297,823	36,435	172,295	8,362	14.00
15.00	01500	PHARMACY	1,133,693	4,725	22,345	101,328	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	25,653	9,629	45,536	0	16.00
17.00	01700	SOCIAL SERVICE	452,036	0	0	0	17.00
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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	16,436,306	133,212	629,934	1,399,363	30.00
31.00	03100	INTENSIVE CARE UNIT	4,169,263	12,016	56,820	183,128	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	901,260	63,307	299,366	78,324	50.00
53.00	05300	ANESTHESIOLOGY	163	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	733,997	16,310	77,128	53,538	54.00
56.00	05600	RADIOISOTOPE	57,437	3,095	14,633	5,279	56.00
57.00	05700	CT SCAN	136,619	1,960	9,270	13,368	57.00
57.01	03630	ULTRA SOUND	131,060	1,019	4,818	13,035	57.01
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	2,670,662	16,423	77,662	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,726,569	325	1,536	364,486	65.00
66.00	06600	PHYSICAL THERAPY	2,174,976	24,841	117,467	216,831	66.00
69.00	06900	ELECTROCARDIOLOGY	21,565	2,021	9,559	2,163	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	140,774	8,815	41,686	13,823	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,814,434	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	499,128	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,431,742	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	810,335	1,203	5,686	67,596	74.00
76.00	03950	SUBSTANCE ABUSE	375,149	2,165	10,238	33,602	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	112,409	7,810	36,934	9,461	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	92,892	7,114	33,640	8,576	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	80,828,068	1,011,955	4,785,342	3,061,192	118.00
NONREIMBURSABLE COST CENTERS							
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)	80,828,068	1,011,955	4,785,342	3,061,192	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCO UNTS RECEIVABLE	Subtotal	
		5.02	5.03	5.04	5.05	5A.05	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING	8,441				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	174	2,988			5.03
5.04	00570	ADMITTING	0	0	0		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	767	0	0	7,069	5.05
5.06	00590	ADMINISTRATIVE & GENERAL	2,582	38	0	0	5.06
6.00	00600	MAINTENANCE & REPAIRS	105	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	35	4	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	35	18	0	0	8.00
9.00	00900	HOUSEKEEPING	35	8	0	0	9.00
10.00	01000	DIETARY	35	0	0	0	10.00
11.00	01100	CAFETERIA	35	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	23	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	35	0	0	0	14.00
15.00	01500	PHARMACY	174	1,080	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	767	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	488	1,082	0	2,530	30.00
31.00	03100	INTENSIVE CARE UNIT	0	108	0	246	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	453	133	0	111	50.00
53.00	05300	ANESTHESIOLOGY	0	2	0	25	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,151	95	0	88	54.00
56.00	05600	RADIOISOTOPE	0	8	0	4	56.00
57.00	05700	CT SCAN	0	3	0	80	57.00
57.01	03630	ULTRA SOUND	0	1	0	59	57.01
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	907	59	0	632	60.00
65.00	06500	RESPIRATORY THERAPY	174	151	0	1,397	65.00
66.00	06600	PHYSICAL THERAPY	349	9	0	261	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	47	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	105	3	0	31	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	212	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	46	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,002	73.00
74.00	07400	RENAL DIALYSIS	0	45	0	180	74.00
76.00	03950	SUBSTANCE ABUSE	0	16	0	16	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	100	0	80	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	35	2	0	22	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,441	2,988	0	7,069	118.00
NONREIMBURSABLE COST CENTERS							
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	8,441	2,988	0	7,069	202.00

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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.06	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	ADMINISTRATIVE & GENERAL	23,181,747				5.06
6.00	00600	MAINTENANCE & REPAIRS	314,457	1,096,422			6.00
7.00	00700	OPERATION OF PLANT	1,964,828	332,489	7,183,283		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	153,741	27,091	254,739	817,881	8.00
9.00	00900	HOUSEKEEPING	656,598	19,324	181,708	0	9.00
10.00	01000	DIETARY	286,425	58,992	554,702	0	10.00
11.00	01100	CAFETERIA	447,378	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	446,147	14,829	139,433	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	207,533	66,548	625,753	0	14.00
15.00	01500	PHARMACY	509,033	8,631	81,154	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	36,112	17,588	165,380	0	16.00
17.00	01700	SOCIAL SERVICE	181,780	0	0	0	17.00
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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,493,396	243,309	2,287,839	536,729	30.00
31.00	03100	INTENSIVE CARE UNIT	1,778,308	21,946	206,361	61,370	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	544,034	115,629	1,087,257	40,384	50.00
53.00	05300	ANESTHESIOLOGY	393	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	358,655	29,790	280,120	2,391	54.00
56.00	05600	RADIOISOTOPE	32,354	5,652	53,146	146	56.00
57.00	05700	CT SCAN	64,865	3,580	33,666	2,503	57.00
57.01	03630	ULTRA SOUND	60,317	1,861	17,500	3,941	57.01
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	1,115,120	29,997	282,060	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,647,692	593	5,577	373	65.00
66.00	06600	PHYSICAL THERAPY	1,020,306	45,371	426,626	25,997	66.00
69.00	06900	ELECTROCARDIOLOGY	14,218	3,692	34,717	647	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	83,077	16,101	151,396	920	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,534,010	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	200,736	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,380,433	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	355,955	2,196	20,652	0	74.00
76.00	03950	SUBSTANCE ABUSE	169,374	3,954	37,182	107,616	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	67,165	14,266	134,139	31,737	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	57,307	12,993	122,176	3,127	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,181,747	1,096,422	7,183,283	817,881	118.00
NONREIMBURSABLE COST CENTERS							
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	23,181,747	1,096,422	7,183,283	817,881	202.00

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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	ADMINISTRATIVE & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,817,128					10.00
11.00	01100	CAFETERIA	0	1,559,880				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	32,513	0	1,793,831		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,610	0	0	1,653,498	14.00
15.00	01500	PHARMACY	0	48,329	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
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
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,751,846	879,070	0	1,381,748	0	30.00
31.00	03100	INTENSIVE CARE UNIT	65,282	82,996	0	222,358	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	41,914	0	88,458	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	30,065	0	9,304	0	54.00
56.00	05600	RADIOISOTOPE	0	2,399	0	0	0	56.00
57.00	05700	CT SCAN	0	5,925	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	6,708	0	0	0	57.01
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	208,444	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	128,631	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,616	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	10,430	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,462,169	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	191,329	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,567	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	35,989	0	80,232	0	74.00
76.00	03950	SUBSTANCE ABUSE	0	24,727	0	674	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	6,757	0	11,057	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	5,190	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,817,128	1,559,880	0	1,793,831	1,653,498	118.00
NONREIMBURSABLE COST CENTERS								
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)	1,817,128	1,559,880	0	1,793,831	1,653,498	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICES	INTERNS & RESIDENTS		
					SERVICES-SALARIES & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	
		15.00	16.00	17.00	21.00	22.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	ADMINISTRATIVE & GENERAL					5.06
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY	1,942,924				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	369,926			16.00
17.00	01700	SOCIAL SERVICE	0	0	633,816		17.00
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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	129,382	332,925	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	13,048	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	5,878	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	1,303	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,653	0	0	54.00
56.00	05600	RADIOISOTOPE	0	227	0	0	56.00
57.00	05700	CT SCAN	0	4,215	0	0	57.00
57.01	03630	ULTRA SOUND	0	3,131	0	0	57.01
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	33,498	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	74,029	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	13,843	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,493	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,651	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	11,243	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,439	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,942,924	53,081	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	9,514	0	0	74.00
76.00	03950	SUBSTANCE ABUSE	0	869	300,891	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	4,245	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	1,184	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,942,924	369,926	633,816	0	118.00
NONREIMBURSABLE COST CENTERS							
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,942,924	369,926	633,816	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-2011

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/29/2021 12:20 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00540	NONPATIENT TELEPHONES			5.01
5.02	00550	DATA PROCESSING			5.02
5.03	00560	PURCHASING RECEIVING AND STORES			5.03
5.04	00570	ADMITTING			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.05
5.06	00590	ADMINISTRATIVE & GENERAL			5.06
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	34,514,597	0	34,514,597
31.00	03100	INTENSIVE CARE UNIT	6,949,985	0	6,949,985
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,677,742	0	3,677,742
53.00	05300	ANESTHESIOLOGY	2,674	0	2,674
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,710,249	0	1,710,249
56.00	05600	RADIOISOTOPE	193,997	0	193,997
57.00	05700	CT SCAN	288,481	0	288,481
57.01	03630	ULTRA SOUND	249,910	0	249,910
58.00	05800	MRI	0	0	0
60.00	06000	LABORATORY	4,337,774	0	4,337,774
65.00	06500	RESPIRATORY THERAPY	6,036,106	0	6,036,106
66.00	06600	PHYSICAL THERAPY	4,355,461	0	4,355,461
69.00	06900	ELECTROCARDIOLOGY	105,553	0	105,553
70.00	07000	ELECTROENCEPHALOGRAPHY	526,047	0	526,047
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,822,068	0	6,822,068
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	893,678	0	893,678
73.00	07300	DRUGS CHARGED TO PATIENTS	6,810,749	0	6,810,749
74.00	07400	RENAL DIALYSIS	1,397,319	0	1,397,319
76.00	03950	SUBSTANCE ABUSE	1,080,198	0	1,080,198
76.97	07697	CARDIAC REHABILITATION	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	485,899	0	485,899
76.99	07699	LITHOTRIPSY	0	0	0
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0
90.02	09001	WOMENS DIAGNOSTIC CENTER	389,581	0	389,581
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	80,828,068	0	80,828,068
NONREIMBURSABLE COST CENTERS					
200.00		Cross Foot Adjustments	0	0	0
201.00		Negative Cost Centers	0	0	0
202.00		TOTAL (sum lines 118 through 201)	80,828,068	0	80,828,068

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-2011

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/29/2021 12:20 pm

Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
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	11,536	54,549	66,085	66,085	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	0	0	5.01
5.02	00550	DATA PROCESSING	0	0	0	0	0	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	0	0	0	0	5.03
5.04	00570	ADMITTING	0	0	0	0	0	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.05
5.06	00590	ADMINISTRATIVE & GENERAL	0	396,130	1,873,220	2,269,350	7,982	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	3,998	18,906	22,904	0	6.00
7.00	00700	OPERATION OF PLANT	0	182,037	860,818	1,042,855	860	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	14,832	70,140	84,972	0	8.00
9.00	00900	HOUSEKEEPING	0	10,580	50,032	60,612	0	9.00
10.00	01000	DIETARY	0	32,298	152,732	185,030	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	8,119	38,392	46,511	1,714	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	36,435	172,295	208,730	181	14.00
15.00	01500	PHARMACY	0	4,725	22,345	27,070	2,188	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,629	45,536	55,165	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
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
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	133,212	629,934	763,146	30,207	30.00
31.00	03100	INTENSIVE CARE UNIT	0	12,016	56,820	68,836	3,954	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	63,307	299,366	362,673	1,691	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,310	77,128	93,438	1,156	54.00
56.00	05600	RADIOISOTOPE	0	3,095	14,633	17,728	114	56.00
57.00	05700	CT SCAN	0	1,960	9,270	11,230	289	57.00
57.01	03630	ULTRA SOUND	0	1,019	4,818	5,837	281	57.01
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	16,423	77,662	94,085	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	325	1,536	1,861	7,869	65.00
66.00	06600	PHYSICAL THERAPY	0	24,841	117,467	142,308	4,681	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,021	9,559	11,580	47	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	8,815	41,686	50,501	298	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	1,203	5,686	6,889	1,459	74.00
76.00	03950	SUBSTANCE ABUSE	0	2,165	10,238	12,403	725	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	7,810	36,934	44,744	204	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	7,114	33,640	40,754	185	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,011,955	4,785,342	5,797,297	66,085	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,011,955	4,785,342	5,797,297	66,085	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-2011

Period:
From 07/01/2020
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Cost Center Description			NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	0					5.01
5.02	00550	DATA PROCESSING	0	0				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	0	0			5.03
5.04	00570	ADMITTING	0	0	0	0		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.05
5.06	00590	ADMINISTRATIVE & GENERAL	0	0	0	0	0	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	0	9.00
10.00	01000	DIETARY	0	0	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	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	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
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
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	SUBSTANCE ABUSE	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
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	0	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-2011

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.06	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	ADMINISTRATIVE & GENERAL	2,277,332				5.06
6.00	00600	MAINTENANCE & REPAIRS	30,892	53,796			6.00
7.00	00700	OPERATION OF PLANT	193,020	16,314	1,253,049		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	15,103	1,329	44,437	145,841	8.00
9.00	00900	HOUSEKEEPING	64,503	948	31,697	0	9.00
10.00	01000	DIETARY	28,138	2,894	96,762	0	10.00
11.00	01100	CAFETERIA	43,949	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	43,828	728	24,323	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	20,388	3,265	109,156	0	14.00
15.00	01500	PHARMACY	50,006	423	14,157	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,548	863	28,849	0	16.00
17.00	01700	SOCIAL SERVICE	17,858	0	0	0	17.00
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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	736,144	11,938	399,087	95,708	30.00
31.00	03100	INTENSIVE CARE UNIT	174,697	1,077	35,998	10,943	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	53,445	5,673	189,661	7,201	50.00
53.00	05300	ANESTHESIOLOGY	39	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,233	1,462	48,864	426	54.00
56.00	05600	RADIOISOTOPE	3,178	277	9,271	26	56.00
57.00	05700	CT SCAN	6,372	176	5,873	446	57.00
57.01	03630	ULTRA SOUND	5,925	91	3,053	703	57.01
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	109,547	1,472	49,202	0	60.00
65.00	06500	RESPIRATORY THERAPY	161,865	29	973	66	65.00
66.00	06600	PHYSICAL THERAPY	100,232	2,226	74,420	4,636	66.00
69.00	06900	ELECTROCARDIOLOGY	1,397	181	6,056	115	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,161	790	26,410	164	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	150,698	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,720	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	135,611	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	34,968	108	3,603	0	74.00
76.00	03950	SUBSTANCE ABUSE	16,639	194	6,486	19,190	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	6,598	700	23,399	5,659	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	5,630	638	21,312	558	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,277,332	53,796	1,253,049	145,841	118.00
NONREIMBURSABLE COST CENTERS							
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,277,332	53,796	1,253,049	145,841	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-2011

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/29/2021 12:20 pm

Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	ADMINISTRATIVE & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	325,794					10.00
11.00	01100	CAFETERIA	0	43,949				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	916	0	121,280		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	186	0	0	356,538	14.00
15.00	01500	PHARMACY	0	1,362	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
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
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	314,090	24,767	0	93,418	0	30.00
31.00	03100	INTENSIVE CARE UNIT	11,704	2,338	0	15,034	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,181	0	5,981	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	847	0	629	0	54.00
56.00	05600	RADIOISOTOPE	0	68	0	0	0	56.00
57.00	05700	CT SCAN	0	167	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	189	0	0	0	57.01
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,873	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,624	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	46	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	294	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	315,283	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	41,255	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	44	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	1,014	0	5,424	0	74.00
76.00	03950	SUBSTANCE ABUSE	0	697	0	46	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	190	0	748	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	146	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	325,794	43,949	0	121,280	356,538	118.00
NONREIMBURSABLE COST CENTERS								
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)	325,794	43,949	0	121,280	356,538	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-2011

Period:
From 07/01/2020
To 06/30/2021Worksheet B
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Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICES	INTERNS & RESIDENTS		
					SERVICES-SALARIES & FRINGES	SERVICES-OTHER	
					APPRV	PRGM COSTS APPRV	
		15.00	16.00	17.00	21.00	22.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	ADMINISTRATIVE & GENERAL					5.06
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY	97,104				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	92,292			16.00
17.00	01700	SOCIAL SERVICE	0	0	17,858		17.00
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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	32,156	9,380		30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,262	0		31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,469	0		50.00
53.00	05300	ANESTHESIOLOGY	0	326	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,163	0		54.00
56.00	05600	RADIOISOTOPE	0	57	0		56.00
57.00	05700	CT SCAN	0	1,054	0		57.00
57.01	03630	ULTRA SOUND	0	783	0		57.01
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	8,375	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	18,507	0		65.00
66.00	06600	PHYSICAL THERAPY	0	3,461	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	623	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	413	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,811	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	610	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	97,104	13,270	0		73.00
74.00	07400	RENAL DIALYSIS	0	2,378	0		74.00
76.00	03950	SUBSTANCE ABUSE	0	217	8,478		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	1,061	0		76.98
76.99	07699	LITHOTRIPSY	0	0	0		76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0		90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	296	0		90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	97,104	92,292	17,858	0	118.00
NONREIMBURSABLE COST CENTERS							
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	97,104	92,292	17,858	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-2011

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00540	NONPATIENT TELEPHONES			5.01
5.02	00550	DATA PROCESSING			5.02
5.03	00560	PURCHASING RECEIVING AND STORES			5.03
5.04	00570	ADMITTING			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.05
5.06	00590	ADMINISTRATIVE & GENERAL			5.06
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,563,538	0	2,563,538
31.00	03100	INTENSIVE CARE UNIT	332,668	0	332,668
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	654,398	0	654,398
53.00	05300	ANESTHESIOLOGY	365	0	365
54.00	05400	RADIOLOGY-DIAGNOSTIC	189,768	0	189,768
56.00	05600	RADIOISOTOPE	31,962	0	31,962
57.00	05700	CT SCAN	26,394	0	26,394
57.01	03630	ULTRA SOUND	17,271	0	17,271
58.00	05800	MRI	0	0	0
60.00	06000	LABORATORY	269,276	0	269,276
65.00	06500	RESPIRATORY THERAPY	197,173	0	197,173
66.00	06600	PHYSICAL THERAPY	345,564	0	345,564
69.00	06900	ELECTROCARDIOLOGY	20,857	0	20,857
70.00	07000	ELECTROENCEPHALOGRAPHY	90,571	0	90,571
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	468,792	0	468,792
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	61,585	0	61,585
73.00	07300	DRUGS CHARGED TO PATIENTS	246,029	0	246,029
74.00	07400	RENAL DIALYSIS	56,326	0	56,326
76.00	03950	SUBSTANCE ABUSE	65,944	0	65,944
76.97	07697	CARDIAC REHABILITATION	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	86,440	0	86,440
76.99	07699	LITHOTRIPSY	0	0	0
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0
90.02	09001	WOMENS DIAGNOSTIC CENTER	72,376	0	72,376
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,797,297	0	5,797,297
NONREIMBURSABLE COST CENTERS					
200.00		Cross Foot Adjustments	0	0	0
201.00		Negative Cost Centers	0	0	0
202.00		TOTAL (sum lines 118 through 201)	5,797,297	0	5,797,297

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:14-2011

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

Worksheet B-1

Date/Time Prepared:
11/29/2021 12:20 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF LINES)	DATA PROCESSING (NUMBER OF INSTRUMENT)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00				
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	430,027					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		430,027				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,902	4,902	28,476,025			4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	1,101		5.01
5.02	00550	DATA PROCESSING	0	0	0	75	242	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	0	0	25	5	5.03
5.04	00570	ADMITTING	0	0	0	0	0	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	56	22	5.05
5.06	00590	ADMINISTRATIVE & GENERAL	168,334	168,334	3,439,096	195	74	5.06
6.00	00600	MAINTENANCE & REPAIRS	1,699	1,699	0	15	3	6.00
7.00	00700	OPERATION OF PLANT	77,356	77,356	370,574	21	1	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,303	6,303	0	0	1	8.00
9.00	00900	HOUSEKEEPING	4,496	4,496	0	8	1	9.00
10.00	01000	DIETARY	13,725	13,725	0	7	1	10.00
11.00	01100	CAFETERIA	0	0	0	10	1	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	3,450	3,450	738,471	2	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	15,483	15,483	77,789	10	1	14.00
15.00	01500	PHARMACY	2,008	2,008	942,580	22	5	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,092	4,092	0	73	22	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
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
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	56,608	56,608	13,017,274	275	14	30.00
31.00	03100	INTENSIVE CARE UNIT	5,106	5,106	1,703,497	5	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	26,902	26,902	728,589	88	13	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	7	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,931	6,931	498,020	85	33	54.00
56.00	05600	RADIOISOTOPE	1,315	1,315	49,107	0	0	56.00
57.00	05700	CT SCAN	833	833	124,355	0	0	57.00
57.01	03630	ULTRA SOUND	433	433	121,255	0	0	57.01
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	6,979	6,979	0	59	26	60.00
65.00	06500	RESPIRATORY THERAPY	138	138	3,390,539	24	5	65.00
66.00	06600	PHYSICAL THERAPY	10,556	10,556	2,017,018	22	10	66.00
69.00	06900	ELECTROCARDIOLOGY	859	859	20,119	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,746	3,746	128,586	12	3	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	511	511	628,790	1	0	74.00
76.00	03950	SUBSTANCE ABUSE	920	920	312,577	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	3,319	3,319	88,011	2	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	3,023	3,023	79,778	2	1	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	430,027	430,027	28,476,025	1,101	242	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,011,955	4,785,342	3,061,192	123,911	8,441	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.353236	11.128004	0.107501	112.544051	34.880165	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			66,085	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002321	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:14-2011

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		PURCHASING RECEIVING AND STORES (COST OF RE QUESTIONS)	ADMITTING (INPATIENT REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVE NUE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		5.03	5.04	5.05	5A.06	5.06	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	9,065,513				5.03
5.04	00570	ADMITTING	0	0			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	436,291,685		5.05
5.06	00590	ADMINISTRATIVE & GENERAL	114,593	0	0	-23,181,747	5.06
6.00	00600	MAINTENANCE & REPAIRS	1,310	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	12,377	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	53,613	0	0	0	8.00
9.00	00900	HOUSEKEEPING	24,603	0	0	0	9.00
10.00	01000	DIETARY	0	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	70,562	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	3,284,155	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	548	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,279,401	0	152,632,667	0	30.00
31.00	03100	INTENSIVE CARE UNIT	328,619	0	15,386,933	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	403,718	0	6,931,252	0	50.00
53.00	05300	ANESTHESIOLOGY	4,583	0	1,536,333	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	287,562	0	5,486,765	0	54.00
56.00	05600	RADIOISOTOPE	24,270	0	267,415	0	56.00
57.00	05700	CT SCAN	8,386	0	4,970,335	0	57.00
57.01	03630	ULTRA SOUND	2,166	0	3,692,210	0	57.01
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	179,769	0	39,502,868	0	60.00
65.00	06500	RESPIRATORY THERAPY	456,249	0	87,298,008	0	65.00
66.00	06600	PHYSICAL THERAPY	26,594	0	16,324,716	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	2,939,620	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,967	0	1,947,243	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	13,258,235	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,875,690	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	62,595,855	0	73.00
74.00	07400	RENAL DIALYSIS	137,067	0	11,219,148	0	74.00
76.00	03950	SUBSTANCE ABUSE	47,528	0	1,024,240	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	302,320	0	5,005,574	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	7,553	0	1,396,578	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,065,513	0	436,291,685	-23,181,747	118.00
NONREIMBURSABLE COST CENTERS							
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)	2,988	0	7,069	23,181,747	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000330	0.000000	0.000016	0.402137	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	0	2,277,332	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.000000	0.039505	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:14-2011

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

Worksheet B-1

Date/Time Prepared:
11/29/2021 12:20 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	ADMINISTRATIVE & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS	255,092					6.00
7.00	00700	OPERATION OF PLANT	77,356	177,736				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,303	6,303	342,411			8.00
9.00	00900	HOUSEKEEPING	4,496	4,496	0	166,937		9.00
10.00	01000	DIETARY	13,725	13,725	0	13,725	98,286	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	3,450	3,450	0	3,450	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	15,483	15,483	0	15,483	0	14.00
15.00	01500	PHARMACY	2,008	2,008	0	2,008	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,092	4,092	0	4,092	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
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
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	56,608	56,608	224,705	56,608	94,755	30.00
31.00	03100	INTENSIVE CARE UNIT	5,106	5,106	25,693	5,106	3,531	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	26,902	26,902	16,907	26,902	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,931	6,931	1,001	6,931	0	54.00
56.00	05600	RADIOISOTOPE	1,315	1,315	61	1,315	0	56.00
57.00	05700	CT SCAN	833	833	1,048	833	0	57.00
57.01	03630	ULTRA SOUND	433	433	1,650	433	0	57.01
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	6,979	6,979	0	6,979	0	60.00
65.00	06500	RESPIRATORY THERAPY	138	138	156	138	0	65.00
66.00	06600	PHYSICAL THERAPY	10,556	10,556	10,884	10,556	0	66.00
69.00	06900	ELECTROCARDIOLOGY	859	859	271	859	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,746	3,746	385	3,746	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	511	511	0	511	0	74.00
76.00	03950	SUBSTANCE ABUSE	920	920	45,054	920	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	3,319	3,319	13,287	3,319	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	3,023	3,023	1,309	3,023	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	255,092	177,736	342,411	166,937	98,286	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,096,422	7,183,283	817,881	2,490,401	1,817,128	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.298143	40.415465	2.388594	14.918209	18.488167	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	53,796	1,253,049	145,841	157,760	325,794	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.210889	7.050057	0.425924	0.945027	3.314755	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:14-2011

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

Worksheet B-1

Date/Time Prepared:
11/29/2021 12:20 pm

Cost Center Description		CAFETERIA (FTES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	ADMINISTRATIVE & GENERAL					5.06
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA	31,857				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	664	0	13,303		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	135	0	0	4,313,559	14.00
15.00	01500	PHARMACY	987	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	17,953	0	10,247	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,695	0	1,649	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	856	0	656	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	614	0	69	0	54.00
56.00	05600	RADIOISOTOPE	49	0	0	0	56.00
57.00	05700	CT SCAN	121	0	0	0	57.00
57.01	03630	ULTRA SOUND	137	0	0	0	57.01
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	4,257	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,627	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	33	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	213	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,814,431	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	499,128	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	735	0	595	0	74.00
76.00	03950	SUBSTANCE ABUSE	505	0	5	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	138	0	82	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	106	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,857	0	13,303	4,313,559	118.00
NONREIMBURSABLE COST CENTERS							
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,559,880	0	1,793,831	1,653,498	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	48.965063	0.000000	134.844095	0.383326	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	43,949	0	121,280	356,538	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.379571	0.000000	9.116741	0.082655	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:14-2011

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

Worksheet B-1

Date/Time Prepared:
11/29/2021 12:20 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	SOCIAL SERVICES (TIME SPENT)	INTERNS & RESIDENTS			
					SERVICES-SALAR	SERVICES-OTHER		
					Y & FRINGES APPRV (ASSIGNED TIME)	PRGM COSTS APPRV (ASSIGNED TIME)		
			16.00	17.00	21.00	22.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	ADMINISTRATIVE & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	436,291,685					16.00
17.00	01700	SOCIAL SERVICE	0	1,662				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		0		22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	152,632,667	873	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	15,386,933	0	0	0		31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,931,252	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	1,536,333	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,486,765	0	0	0		54.00
56.00	05600	RADIOISOTOPE	267,415	0	0	0		56.00
57.00	05700	CT SCAN	4,970,335	0	0	0		57.00
57.01	03630	ULTRA SOUND	3,692,210	0	0	0		57.01
58.00	05800	MRI	0	0	0	0		58.00
60.00	06000	LABORATORY	39,502,868	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	87,298,008	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	16,324,716	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	2,939,620	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,947,243	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,258,235	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,875,690	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	62,595,855	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	11,219,148	0	0	0		74.00
76.00	03950	SUBSTANCE ABUSE	1,024,240	789	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	5,005,574	0	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0	0	0		76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0		90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	1,396,578	0	0	0		90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	436,291,685	1,662	0	0		118.00
NONREIMBURSABLE COST CENTERS								
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)	369,926	633,816	0	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000848	381.357401	0.000000	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	92,292	17,858	0	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000212	10.744886	0.000000	0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Worksheet C
Part I
Date/Time Prepared:
11/29/2021 12:20 pm

MCRIF32 - 16.12.172.6

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-2011

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/29/2021 12:20 pm

					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	152,632,667		152,632,667				30.00	
31.00	03100	INTENSIVE CARE UNIT	15,386,933		15,386,933				31.00	
ANCILLARY SERVICE COST CENTERS										
50.00	05000	OPERATING ROOM	1,803,617	5,127,635	6,931,252	0.530603	0.000000	50.00		
53.00	05300	ANESTHESIOLOGY	325,991	1,210,342	1,536,333	0.001741	0.000000	53.00		
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,557,963	928,802	5,486,765	0.311704	0.000000	54.00		
56.00	05600	RADIOISOTOPE	55,158	212,257	267,415	0.725453	0.000000	56.00		
57.00	05700	CT SCAN	3,781,447	1,188,888	4,970,335	0.058041	0.000000	57.00		
57.01	03630	ULTRA SOUND	1,174,048	2,518,162	3,692,210	0.067686	0.000000	57.01		
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00		
60.00	06000	LABORATORY	32,806,079	6,696,789	39,502,868	0.109809	0.000000	60.00		
65.00	06500	RESPIRATORY THERAPY	87,279,932	18,076	87,298,008	0.069144	0.000000	65.00		
66.00	06600	PHYSICAL THERAPY	13,686,501	2,638,215	16,324,716	0.266802	0.000000	66.00		
69.00	06900	ELECTROCARDIOLOGY	2,461,925	477,695	2,939,620	0.035907	0.000000	69.00		
70.00	07000	ELECTROENCEPHALOGRAPHY	67,458	1,879,785	1,947,243	0.270150	0.000000	70.00		
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,224,871	1,033,364	13,258,235	0.514553	0.000000	71.00		
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	786,369	2,089,321	2,875,690	0.310770	0.000000	72.00		
73.00	07300	DRUGS CHARGED TO PATIENTS	58,871,458	3,724,397	62,595,855	0.108805	0.000000	73.00		
74.00	07400	RENAL DIALYSIS	10,676,969	542,179	11,219,148	0.124548	0.000000	74.00		
76.00	03950	SUBSTANCE ABUSE	0	1,024,240	1,024,240	1.054634	0.000000	76.00		
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97		
76.98	07698	HYPERBARIC OXYGEN THERAPY	66,598	4,938,976	5,005,574	0.097072	0.000000	76.98		
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99		
OUTPATIENT SERVICE COST CENTERS										
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00		
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	1,396,578	1,396,578	0.278954	0.000000	90.02		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00		
SPECIAL PURPOSE COST CENTERS										
113.00	11300	INTEREST EXPENSE						113.00		
200.00		Subtotal (see instructions)	398,645,984	37,645,701	436,291,685			200.00		
201.00		Less Observation Beds						201.00		
202.00		Total (see instructions)	398,645,984	37,645,701	436,291,685			202.00		

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-2011

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/29/2021 12:20 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.530603			50.00
53.00	05300 ANESTHESIOLOGY	0.001741			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.311704			54.00
56.00	05600 RADIOISOTOPE	0.725453			56.00
57.00	05700 CT SCAN	0.058041			57.00
57.01	03630 ULTRA SOUND	0.067686			57.01
58.00	05800 MRI	0.000000			58.00
60.00	06000 LABORATORY	0.109980			60.00
65.00	06500 RESPIRATORY THERAPY	0.069144			65.00
66.00	06600 PHYSICAL THERAPY	0.266802			66.00
69.00	06900 ELECTROCARDIOLOGY	0.035907			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.270150			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.514553			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.310770			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.108805			73.00
74.00	07400 RENAL DIALYSIS	0.124548			74.00
76.00	03950 SUBSTANCE ABUSE	1.054634			76.00
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.097844			76.98
76.99	07699 LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	0.278954			90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

Worksheet C
Part I
Date/Time Prepared:
11/29/2021 12:20 pm

MCRIF32 - 16.12.172.6

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-2011

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/29/2021 12:20 pm

					Title XIX		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	152,632,667		152,632,667			30.00		
31.00	03100	INTENSIVE CARE UNIT	15,386,933		15,386,933			31.00		
	ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	1,803,617	5,127,635	6,931,252	0.530603	0.000000	50.00		
53.00	05300	ANESTHESIOLOGY	325,991	1,210,342	1,536,333	0.001741	0.000000	53.00		
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,557,963	928,802	5,486,765	0.311704	0.000000	54.00		
56.00	05600	RADIOISOTOPE	55,158	212,257	267,415	0.725453	0.000000	56.00		
57.00	05700	CT SCAN	3,781,447	1,188,888	4,970,335	0.058041	0.000000	57.00		
57.01	03630	ULTRA SOUND	1,174,048	2,518,162	3,692,210	0.067686	0.000000	57.01		
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00		
60.00	06000	LABORATORY	32,806,079	6,696,789	39,502,868	0.109809	0.000000	60.00		
65.00	06500	RESPIRATORY THERAPY	87,279,932	18,076	87,298,008	0.069144	0.000000	65.00		
66.00	06600	PHYSICAL THERAPY	13,686,501	2,638,215	16,324,716	0.266802	0.000000	66.00		
69.00	06900	ELECTROCARDIOLOGY	2,461,925	477,695	2,939,620	0.035907	0.000000	69.00		
70.00	07000	ELECTROENCEPHALOGRAPHY	67,458	1,879,785	1,947,243	0.270150	0.000000	70.00		
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,224,871	1,033,364	13,258,235	0.514553	0.000000	71.00		
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	786,369	2,089,321	2,875,690	0.310770	0.000000	72.00		
73.00	07300	DRUGS CHARGED TO PATIENTS	58,871,458	3,724,397	62,595,855	0.108805	0.000000	73.00		
74.00	07400	RENAL DIALYSIS	10,676,969	542,179	11,219,148	0.124548	0.000000	74.00		
76.00	03950	SUBSTANCE ABUSE	0	1,024,240	1,024,240	1.054634	0.000000	76.00		
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97		
76.98	07698	HYPERBARIC OXYGEN THERAPY	66,598	4,938,976	5,005,574	0.097072	0.000000	76.98		
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99		
	OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00		
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	1,396,578	1,396,578	0.278954	0.000000	90.02		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00		
	SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00		
200.00		Subtotal (see instructions)	398,645,984	37,645,701	436,291,685			200.00		
201.00		Less Observation Beds						201.00		
202.00		Total (see instructions)	398,645,984	37,645,701	436,291,685			202.00		

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-2011

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/29/2021 12:20 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.530603			50.00
53.00	05300 ANESTHESIOLOGY	0.001741			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.311704			54.00
56.00	05600 RADIOISOTOPE	0.725453			56.00
57.00	05700 CT SCAN	0.058041			57.00
57.01	03630 ULTRA SOUND	0.067686			57.01
58.00	05800 MRI	0.000000			58.00
60.00	06000 LABORATORY	0.109980			60.00
65.00	06500 RESPIRATORY THERAPY	0.069144			65.00
66.00	06600 PHYSICAL THERAPY	0.266802			66.00
69.00	06900 ELECTROCARDIOLOGY	0.035907			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.270150			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.514553			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.310770			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.108805			73.00
74.00	07400 RENAL DIALYSIS	0.124548			74.00
76.00	03950 SUBSTANCE ABUSE	1.054634			76.00
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.097844			76.98
76.99	07699 LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	0.278954			90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICAID ONLY

Provider CCN:14-2011

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part II
Date/Time Prepared:
11/29/2021 12:20 pm

Cost Center Description		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
		1.00	2.00	3.00	4.00	5.00	
Title XIX Hospital PPS							
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,677,742	654,398	3,023,344	0	50.00
53.00	05300	ANESTHESIOLOGY	2,674	365	2,309	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,710,249	189,768	1,520,481	0	54.00
56.00	05600	RADIOISOTOPE	193,997	31,962	162,035	0	56.00
57.00	05700	CT SCAN	288,481	26,394	262,087	0	57.00
57.01	03630	ULTRA SOUND	249,910	17,271	232,639	0	57.01
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	4,337,774	269,276	4,068,498	0	60.00
65.00	06500	RESPIRATORY THERAPY	6,036,106	197,173	5,838,933	0	65.00
66.00	06600	PHYSICAL THERAPY	4,355,461	345,564	4,009,897	0	66.00
69.00	06900	ELECTROCARDIOLOGY	105,553	20,857	84,696	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	526,047	90,571	435,476	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,822,068	468,792	6,353,276	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	893,678	61,585	832,093	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,810,749	246,029	6,564,720	0	73.00
74.00	07400	RENAL DIALYSIS	1,397,319	56,326	1,340,993	0	74.00
76.00	03950	SUBSTANCE ABUSE	1,080,198	65,944	1,014,254	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	485,899	86,440	399,459	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	389,581	72,376	317,205	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	39,363,486	2,901,091	36,462,395	0	200.00
201.00		Less Observation Beds	0	0	0	0	201.00
202.00		Total (line 200 minus line 201)	39,363,486	2,901,091	36,462,395	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICAID ONLY

Provider CCN:14-2011

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part II
Date/Time Prepared:
11/29/2021 12:20 pm

Cost Center Description			Title XIX		Hospital	PPS
			Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,677,742	6,931,252	0.530603	50.00
53.00	05300	ANESTHESIOLOGY	2,674	1,536,333	0.001741	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,710,249	5,486,765	0.311704	54.00
56.00	05600	RADIOISOTOPE	193,997	267,415	0.725453	56.00
57.00	05700	CT SCAN	288,481	4,970,335	0.058041	57.00
57.01	03630	ULTRA SOUND	249,910	3,692,210	0.067686	57.01
58.00	05800	MRI	0	0	0.000000	58.00
60.00	06000	LABORATORY	4,337,774	39,502,868	0.109809	60.00
65.00	06500	RESPIRATORY THERAPY	6,036,106	87,298,008	0.069144	65.00
66.00	06600	PHYSICAL THERAPY	4,355,461	16,324,716	0.266802	66.00
69.00	06900	ELECTROCARDIOLOGY	105,553	2,939,620	0.035907	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	526,047	1,947,243	0.270150	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,822,068	13,258,235	0.514553	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	893,678	2,875,690	0.310770	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,810,749	62,595,855	0.108805	73.00
74.00	07400	RENAL DIALYSIS	1,397,319	11,219,148	0.124548	74.00
76.00	03950	SUBSTANCE ABUSE	1,080,198	1,024,240	1.054634	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	485,899	5,005,574	0.097072	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	389,581	1,396,578	0.278954	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (sum of lines 50 thru 199)	39,363,486	268,272,085		200.00
201.00		Less Observation Beds	0	0		201.00
202.00		Total (line 200 minus line 201)	39,363,486	268,272,085		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN:14-2011

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part I
Date/Time Prepared:
11/29/2021 12:20 pm

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,563,538	0	2,563,538	31,585	81.16	30.00
31.00	INTENSIVE CARE UNIT	332,668		332,668	2,326	143.02	31.00
200.00	Total (lines 30 through 199)	2,896,206		2,896,206	33,911		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	12,396	1,006,059				30.00
31.00	INTENSIVE CARE UNIT	644	92,105				31.00
200.00	Total (lines 30 through 199)	13,040	1,098,164				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN:14-2011	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part II Date/Time Prepared: 11/29/2021 12:20 pm
Title XVIII				Hospital		PPS
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	654,398	6,931,252	0.094413	829,435	78,309	50.00
53.00 05300 ANESTHESIOLOGY	365	1,536,333	0.000238	152,497	36	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	189,768	5,486,765	0.034587	1,990,455	68,844	54.00
56.00 05600 RADIOISOTOPE	31,962	267,415	0.119522	24,637	2,945	56.00
57.00 05700 CT SCAN	26,394	4,970,335	0.005310	1,335,743	7,093	57.00
57.01 03630 ULTRA SOUND	17,271	3,692,210	0.004678	475,820	2,226	57.01
58.00 05800 MRI	0	0	0.000000	0	0	58.00
60.00 06000 LABORATORY	269,276	39,502,868	0.006817	12,944,696	88,244	60.00
65.00 06500 RESPIRATORY THERAPY	197,173	87,298,008	0.002259	34,920,353	78,885	65.00
66.00 06600 PHYSICAL THERAPY	345,564	16,324,716	0.021168	5,373,044	113,737	66.00
69.00 06900 ELECTROCARDIOLOGY	20,857	2,939,620	0.007095	1,010,618	7,170	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	90,571	1,947,243	0.046512	27,151	1,263	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	468,792	13,258,235	0.035359	4,869,938	172,196	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	61,585	2,875,690	0.021416	341,125	7,306	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	246,029	62,595,855	0.003930	24,164,445	94,966	73.00
74.00 07400 RENAL DIALYSIS	56,326	11,219,148	0.005021	5,167,384	25,945	74.00
76.00 03950 SUBSTANCE ABUSE	65,944	1,024,240	0.064383	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	86,440	5,005,574	0.017269	226	4	76.98
76.99 07699 LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0.000000	0	0	90.00
90.02 09001 WOMENS DIAGNOSTIC CENTER	72,376	1,396,578	0.051824	0	0	90.02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
200.00 Total (lines 50 through 199)	2,901,091	268,272,085		93,627,567	749,169	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					SP Provider CCN:14-2011		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part III Date/Time Prepared: 11/29/2021 12:20 pm		
					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	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	0	31.00	
200.00		Total (lines 30 through 199)	0	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	31,585	0.00	12,396	0.00	0	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	2,326	0.00	644	0.00	0	31.00	
200.00		Total (lines 30 through 199)		0	33,911		13,040		0	200.00	
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0								30.00
31.00	03100	INTENSIVE CARE UNIT	0								31.00
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:14-2011

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

Worksheet D
Part IV
Date/Time Prepared:
11/29/2021 12:20 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School Post-Stepdown Adjustments	Allied Health Post-Stepdown Adjustments	Allied Health Post-Stepdown Adjustments	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	57.01
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	SUBSTANCE ABUSE	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	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:14-2011

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

Worksheet D
Part IV
Date/Time Prepared:
11/29/2021 12:20 pm

				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	6,931,252	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,536,333	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	5,486,765	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	267,415	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	4,970,335	0.000000	57.00
57.01	03630	ULTRA SOUND	0	0	0	3,692,210	0.000000	57.01
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	39,502,868	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	87,298,008	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	16,324,716	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,939,620	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,947,243	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	13,258,235	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,875,690	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	62,595,855	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	11,219,148	0.000000	74.00
76.00	03950	SUBSTANCE ABUSE	0	0	0	1,024,240	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	5,005,574	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	0	0	1,396,578	0.000000	90.02
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	268,272,085		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:14-2011

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

Worksheet D
Part IV
Date/Time Prepared:
11/29/2021 12:20 pm

				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	829,435	0	1,821,009	0	50.00	
53.00	05300	ANESTHESIOLOGY	0.000000	152,497	0	433,765	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,990,455	0	219,210	0	54.00	
56.00	05600	RADIOISOTOPE	0.000000	24,637	0	46,649	0	56.00	
57.00	05700	CT SCAN	0.000000	1,335,743	0	509,327	0	57.00	
57.01	03630	ULTRA SOUND	0.000000	475,820	0	369,559	0	57.01	
58.00	05800	MRI	0.000000	0	0	0	0	58.00	
60.00	06000	LABORATORY	0.000000	12,944,696	0	800,446	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0.000000	34,920,353	0	2,691	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	5,373,044	0	0	0	66.00	
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,010,618	0	181,510	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	27,151	0	258,032	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	4,869,938	0	378,575	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	341,125	0	590,196	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	24,164,445	0	2,207,770	0	73.00	
74.00	07400	RENAL DIALYSIS	0.000000	5,167,384	0	542,179	0	74.00	
76.00	03950	SUBSTANCE ABUSE	0.000000	0	0	2,606	0	76.00	
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	226	0	2,382,091	0	76.98	
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00	
90.02	09001	WOMENS DIAGNOSTIC CENTER	0.000000	0	0	155,699	0	90.02	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00	
200.00		Total (lines 50 through 199)		93,627,567	0	10,901,314	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-2011

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/29/2021 12:20 pm

			Title XVIII		Hospital		PPS	
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.530603	1,821,009	0	0	966,233	50.00
53.00	05300	ANESTHESIOLOGY	0.001741	433,765	0	0	755	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.311704	219,210	0	0	68,329	54.00
56.00	05600	RADIOISOTOPE	0.725453	46,649	0	0	33,842	56.00
57.00	05700	CT SCAN	0.058041	509,327	0	0	29,562	57.00
57.01	03630	ULTRA SOUND	0.067686	369,559	0	0	25,014	57.01
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.109809	800,446	2,160	0	87,896	60.00
65.00	06500	RESPIRATORY THERAPY	0.069144	2,691	0	0	186	65.00
66.00	06600	PHYSICAL THERAPY	0.266802	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.035907	181,510	0	0	6,517	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.270150	258,032	0	0	69,707	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.514553	378,575	0	0	194,797	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.310770	590,196	0	0	183,415	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.108805	2,207,770	0	448	240,216	73.00
74.00	07400	RENAL DIALYSIS	0.124548	542,179	0	0	67,527	74.00
76.00	03950	SUBSTANCE ABUSE	1.054634	2,606	0	0	2,748	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.097072	2,382,091	0	0	231,234	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0.278954	155,699	0	0	43,433	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Subtotal (see instructions)		10,901,314	2,160	448	2,251,411	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		10,901,314	2,160	448	2,251,411	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-2011

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/29/2021 12:20 pm

				Title XVIII	Hospital	PPS
	Cost Center Description	Costs				
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		6.00	7.00			
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
57.01	03630	ULTRA SOUND	0	0		57.01
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	237	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	49		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	SUBSTANCE ABUSE	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0		90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	0		90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	237	49		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	237	49		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN:14-2011

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part I
Date/Time Prepared:
11/29/2021 12:20 pm

			Title XIX		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,563,538	0	2,563,538	31,585	81.16	30.00
31.00	INTENSIVE CARE UNIT	332,668		332,668	2,326	143.02	31.00
200.00	Total (lines 30 through 199)	2,896,206		2,896,206	33,911		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	6,168	500,595				
31.00	INTENSIVE CARE UNIT	540	77,231				
200.00	Total (lines 30 through 199)	6,708	577,826				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS					Provider CCN:14-2011	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part II Date/Time Prepared: 11/29/2021 12:20 pm	
					Title XIX		Hospital	PPS
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	654,398	6,931,252	0.094413	45,784	4,323	50.00
53.00	05300	ANESTHESIOLOGY	365	1,536,333	0.000238	11,183	3	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	189,768	5,486,765	0.034587	134,446	4,650	54.00
56.00	05600	RADIOISOTOPE	31,962	267,415	0.119522	5,446	651	56.00
57.00	05700	CT SCAN	26,394	4,970,335	0.005310	205,225	1,090	57.00
57.01	03630	ULTRA SOUND	17,271	3,692,210	0.004678	70,196	328	57.01
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	269,276	39,502,868	0.006817	1,233,992	8,412	60.00
65.00	06500	RESPIRATORY THERAPY	197,173	87,298,008	0.002259	1,977,157	4,466	65.00
66.00	06600	PHYSICAL THERAPY	345,564	16,324,716	0.021168	666,476	14,108	66.00
69.00	06900	ELECTROCARDIOLOGY	20,857	2,939,620	0.007095	87,107	618	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	90,571	1,947,243	0.046512	5,777	269	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	468,792	13,258,235	0.035359	1,052,041	37,199	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	61,585	2,875,690	0.021416	6,902	148	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	246,029	62,595,855	0.003930	4,311,442	16,944	73.00
74.00	07400	RENAL DIALYSIS	56,326	11,219,148	0.005021	70,782	355	74.00
76.00	03950	SUBSTANCE ABUSE	65,944	1,024,240	0.064383	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	86,440	5,005,574	0.017269	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	72,376	1,396,578	0.051824	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	2,901,091	268,272,085		9,883,956	93,564	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN:14-2011	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part III Date/Time Prepared: 11/29/2021 12:20 pm
			Title XIX	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	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	31.00
200.00		Total (lines 30 through 199)	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	31,585	0.00	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,326	0.00	31.00
200.00		Total (lines 30 through 199)	0	33,911	6,708	200.00

Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
	9.00	

INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0			30.00
31.00	03100	INTENSIVE CARE UNIT	0			31.00
200.00		Total (lines 30 through 199)	0			200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:14-2011

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

Worksheet D
Part IV
Date/Time Prepared:
11/29/2021 12:20 pm

Cost Center Description		Title XIX		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School Post-Stepdown Adjustments	Allied Health Post-Stepdown Adjustments	Allied Health Post-Stepdown Adjustments	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	57.01
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	SUBSTANCE ABUSE	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	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:14-2011

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

Worksheet D
Part IV
Date/Time Prepared:
11/29/2021 12:20 pm

				Title XIX		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	6,931,252	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,536,333	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	5,486,765	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	267,415	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	4,970,335	0.000000	57.00
57.01	03630	ULTRA SOUND	0	0	0	3,692,210	0.000000	57.01
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	39,502,868	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	87,298,008	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	16,324,716	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,939,620	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,947,243	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	13,258,235	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,875,690	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	62,595,855	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	11,219,148	0.000000	74.00
76.00	03950	SUBSTANCE ABUSE	0	0	0	1,024,240	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	5,005,574	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	0	0	1,396,578	0.000000	90.02
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	268,272,085		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:14-2011

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

Worksheet D
Part IV
Date/Time Prepared:
11/29/2021 12:20 pm

				Title XIX		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	45,784	0	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0.000000	11,183	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	134,446	0	0	0	54.00	
56.00	05600	RADIOISOTOPE	0.000000	5,446	0	0	0	56.00	
57.00	05700	CT SCAN	0.000000	205,225	0	0	0	57.00	
57.01	03630	ULTRA SOUND	0.000000	70,196	0	0	0	57.01	
58.00	05800	MRI	0.000000	0	0	0	0	58.00	
60.00	06000	LABORATORY	0.000000	1,233,992	0	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0.000000	1,977,157	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	666,476	0	0	0	66.00	
69.00	06900	ELECTROCARDIOLOGY	0.000000	87,107	0	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	5,777	0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,052,041	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	6,902	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	4,311,442	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0.000000	70,782	0	0	0	74.00	
76.00	03950	SUBSTANCE ABUSE	0.000000	0	0	0	0	76.00	
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00	
90.02	09001	WOMENS DIAGNOSTIC CENTER	0.000000	0	0	0	0	90.02	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00	
200.00	Total (lines 50 through 199)			9,883,956	0	0	0	200.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN:14-2011	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/29/2021 12:20 pm
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)		31,585	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		31,585	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)		31,585	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)		12,396	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)		34,514,597	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)		34,514,597	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)		34,514,597	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,092.75	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		13,545,729	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)		13,545,729	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN:14-2011		Period: From 07/01/2020 To 06/30/2021		Worksheet D-1 Date/Time Prepared: 11/29/2021 12:20 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
			1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)							42.00
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT		6,949,985	2,326	2,987.96	644	1,924,246	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								
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)						12,388,432	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						27,858,407	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 II)						998,164	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						749,169	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						1,847,333	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						26,011,074	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:14-2011

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

Worksheet D-1

Date/Time Prepared:
11/29/2021 12:20 pm

		Title XVIII		Hospital	PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,563,538	34,514,597	0.074274	0	0 90.00
91.00	Nursing School cost	0	34,514,597	0.000000	0	0 91.00
92.00	Allied health cost	0	34,514,597	0.000000	0	0 92.00
93.00	All other Medical Education	0	34,514,597	0.000000	0	0 93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN:14-2011	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/29/2021 12:20 pm
Cost Center Description		Title XIX	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)		31,585	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		31,585	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)		31,585	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)		6,168	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)		34,514,597	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)		34,514,597	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)		34,514,597	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,092.75	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		6,740,082	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		6,740,082	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN:14-2011

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

Worksheet D-1

Date/Time Prepared:
11/29/2021 12:20 pm

		Title XIX		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)					42.00
	Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT	6,949,985	2,326	2,987.96	540	1,613,498
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
	Cost Center Description					
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,563,159
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					9,916,739
	PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					77,826
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					93,564
52.00	Total Program excludable cost (sum of lines 50 and 51)					671,390
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					9,245,349
	TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
	PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)					0
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN:14-2011

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

Worksheet D-1

Date/Time Prepared:
11/29/2021 12:20 pm

		Title XIX		Hospital	PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,563,538	34,514,597	0.074274	0	0 90.00
91.00	Nursing School cost	0	34,514,597	0.000000	0	0 91.00
92.00	Allied health cost	0	34,514,597	0.000000	0	0 92.00
93.00	All other Medical Education	0	34,514,597	0.000000	0	0 93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN:14-2011	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/29/2021 12:20 pm	
Cost Center Description		Title XVIII	Hospital	PPS	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		57,884,741		30.00
31.00	03100 INTENSIVE CARE UNIT		6,767,617		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.530603	829,435	440,101	50.00
53.00	05300 ANESTHESIOLOGY	0.001741	152,497	265	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.311704	1,990,455	620,433	54.00
56.00	05600 RADIOISOTOPE	0.725453	24,637	17,873	56.00
57.00	05700 CT SCAN	0.058041	1,335,743	77,528	57.00
57.01	03630 ULTRA SOUND	0.067686	475,820	32,206	57.01
58.00	05800 MRI	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.109980	12,944,696	1,423,658	60.00
65.00	06500 RESPIRATORY THERAPY	0.069144	34,920,353	2,414,533	65.00
66.00	06600 PHYSICAL THERAPY	0.266802	5,373,044	1,433,539	66.00
69.00	06900 ELECTROCARDIOLOGY	0.035907	1,010,618	36,288	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.270150	27,151	7,335	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.514553	4,869,938	2,505,841	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.310770	341,125	106,011	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.108805	24,164,445	2,629,212	73.00
74.00	07400 RENAL DIALYSIS	0.124548	5,167,384	643,587	74.00
76.00	03950 SUBSTANCE ABUSE	1.054634	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.097844	226	22	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	0.278954	0	0	90.02
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)		93,627,567	12,388,432	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)		93,627,567		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN:14-2011	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/29/2021 12:20 pm	
Cost Center Description		Title XIX	Hospital	PPS	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		7,441,237		30.00
31.00	03100 INTENSIVE CARE UNIT		230,470		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.530603	45,784	24,293	50.00
53.00	05300 ANESTHESIOLOGY	0.001741	11,183	19	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.311704	134,446	41,907	54.00
56.00	05600 RADIOISOTOPE	0.725453	5,446	3,951	56.00
57.00	05700 CT SCAN	0.058041	205,225	11,911	57.00
57.01	03630 ULTRA SOUND	0.067686	70,196	4,751	57.01
58.00	05800 MRI	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.109980	1,233,992	135,714	60.00
65.00	06500 RESPIRATORY THERAPY	0.069144	1,977,157	136,709	65.00
66.00	06600 PHYSICAL THERAPY	0.266802	666,476	177,817	66.00
69.00	06900 ELECTROCARDIOLOGY	0.035907	87,107	3,128	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.270150	5,777	1,561	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.514553	1,052,041	541,331	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.310770	6,902	2,145	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.108805	4,311,442	469,106	73.00
74.00	07400 RENAL DIALYSIS	0.124548	70,782	8,816	74.00
76.00	03950 SUBSTANCE ABUSE	1.054634	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.097844	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	0.278954	0	0	90.02
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)		9,883,956	1,563,159	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)		9,883,956		202.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN:14-2011

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/29/2021 12:20 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	0
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0	0	0	0	0
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0	0	0
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0	0	0	0
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	0	0	0
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000	10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0
11.01	Uncompensated care payments	36.00	0	0	0	0	0
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	0	0	0	0	0
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	0	0	0	0	0
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	0	0	0	0	0
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0
17.01	Net organ acquisition cost						17.01

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN:14-2011

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/29/2021 12:20 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	0	0	0
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	0	0	0	0	0
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	0	0	0	0	0
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0
26.00	Total prospective capital payments (see instructions)	12.00	0	0	0	0	0
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.000000	0.000000	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN:14-2011

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/29/2021 12:20 pm

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0		0	0	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	0	0	0	0	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	0	0	0	0	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	0	0	0	0	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL				0	0	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN:14-2011

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/29/2021 12:20 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	0	0	0	0	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	0	0	0	0	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	0	0	0	0	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-2011	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/29/2021 12:20 pm
		Title XVIII	Hospital	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		286	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		2,251,411	2.00
3.00	OPPS payments		1,408,910	3.00
4.00	Outlier payment (see instructions)		25,203	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		286	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		2,608	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		2,608	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		2,608	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		2,322	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)		286	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)		1,434,113	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)		287,018	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)		1,147,381	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)		1,147,381	30.00
31.00	Primary payer payments		1,427	31.00
32.00	Subtotal (line 30 minus line 31)		1,145,954	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)		36,187	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		23,522	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		24,519	36.00
37.00	Subtotal (see instructions)		1,169,476	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)		1,169,476	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		1,145,759	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)		23,717	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:14-2011

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part I
Date/Time Prepared:
11/29/2021 12:20 pm

		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		23,324,223		1,145,759	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		23,324,223		1,145,759	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		514,060		23,717	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		23,838,283		1,169,476	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN:14-2011

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part II
Date/Time Prepared:
11/29/2021 12:20 pm

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-2011	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part IV Date/Time Prepared: 11/29/2021 12:20 pm
		Title XVIII	Hospital	PPS
			1.00	
PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)		21,991,583	1.00
1.01	Full standard payment amount		18,913,415	1.01
1.02	Short stay outlier standard payment amount		3,078,168	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		3,992,664	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)		25,984,247	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)		25,984,247	7.00
8.00	Primary payer payments		0	8.00
9.00	Subtotal (line 7 less line 8).		25,984,247	9.00
10.00	Deductibles		37,292	10.00
11.00	Subtotal (line 9 minus line 10)		25,946,955	11.00
12.00	Coinsurance		2,622,733	12.00
13.00	Subtotal (line 11 minus line 12)		23,324,222	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		790,863	14.00
15.00	Adjusted reimbursable bad debts (see instructions)		514,061	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		632,551	16.00
17.00	Subtotal (sum of lines 13 and 15)		23,838,283	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)		23,838,283	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		23,324,223	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)		514,060	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)		3,992,664	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-2011	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part VII Date/Time Prepared: 11/29/2021 12:20 pm
		Title XIX	Hospital	PPS
		Inpatient	Outpatient	
		1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	7,441,237		8.00
9.00	Ancillary service charges	9,883,956	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	17,325,193	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	17,325,193		16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 12) (see instructions)	17,325,193	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

Health Financial Systems		HOLY FAMILY MEDICAL CENTER		In Lieu of Form CMS-2552-10	
DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN:14-2011	Period: From 07/01/2020 To 06/30/2021	Worksheet E-4 Date/Time Prepared: 11/29/2021 12:20 pm	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.00	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	0.00	0.00	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.00	0.00		17.00
18.00	Per resident amount	0.00	0.00		18.00
19.00	Approved amount for resident costs	0	0	0	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			0	25.00
		Inpatient Part A	Managed Care	Total	
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3, column 2)	02, 13,040	0		26.00
27.00	Total Inpatient Days (see instructions)	33,911	33,911		27.00
28.00	Ratio of inpatient days to total inpatient days	0.384536	0.000000		28.00
29.00	Program direct GME amount	0	0	0	29.00
29.01	Percent reduction for MA DGME				29.01
30.00	Reduction for direct GME payments for Medicare Advantage		0	0	30.00
31.00	Net Program direct GME amount			0	31.00

Health Financial Systems		HOLY FAMILY MEDICAL CENTER		In Lieu of Form CMS-2552-10	
DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN:14-2011	Period: From 07/01/2020 To 06/30/2021	Worksheet E-4 Date/Time Prepared: 11/29/2021 12:20 pm	
		Title XVIII	Hospital	PPS	
				1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			11,219,148	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)			27,858,407	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)			0	39.00
40.00	Primary payer payments (see instructions)			0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			27,858,407	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			2,251,697	42.00
43.00	Primary payer payments (see instructions)			1,427	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			2,250,270	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			30,108,677	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.925262	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.074738	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			0	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			0	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			0	50.00

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

Provider CCN:14-2011

Period:

Worksheet G

From 07/01/2020

Date/Time Prepared:

To 06/30/2021

11/29/2021 12:20 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	-5,704	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	70,665,483	0	0	0	4.00
5.00	Other receivable	1,125,910	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-50,882,706	0	0	0	6.00
7.00	Inventory	880,268	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	232,267	0	0	0	9.00
10.00	Due from other funds	1,587,102	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	23,602,620	0	0	0	11.00
FIXED ASSETS						
12.00	Land	6,320,000	0	0	0	12.00
13.00	Land improvements	486,851	0	0	0	13.00
14.00	Accumulated depreciation	-90,620	0	0	0	14.00
15.00	Buildings	26,023,905	0	0	0	15.00
16.00	Accumulated depreciation	-3,739,249	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	3,825,084	0	0	0	19.00
20.00	Accumulated depreciation	-1,207,524	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	4,772,683	0	0	0	23.00
24.00	Accumulated depreciation	-1,720,521	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	102,429	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	34,773,038	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	1,377,055	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	39,457	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,416,512	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	59,792,170	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,123,134	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,319,212	0	0	0	38.00
39.00	Payroll taxes payable	314,738	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	9,540,362	0	0	0	43.00
44.00	Other current liabilities	18,096,866	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	31,394,312	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	707,378	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	707,378	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	32,101,690	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	27,690,480	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)	27,690,480	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	59,792,170	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN:14-2011

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

Worksheet G-1

Date/Time Prepared:
11/29/2021 12:20 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		30,827,610		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-9,162,033				2.00
3.00	Total (sum of line 1 and line 2)		21,665,577		0		3.00
4.00	RECONCILING ITEM	6,024,903		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		6,024,903		0		10.00
11.00	Subtotal (line 3 plus line 10)		27,690,480		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		27,690,480		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	RECONCILING ITEM		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN:14-2011

Period:
From 07/01/2020
To 06/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
11/29/2021 12:20 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	152,632,667		152,632,667	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)	152,632,667		152,632,667	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	15,386,933		15,386,933	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)	15,386,933		15,386,933	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	168,019,600		168,019,600	17.00
18.00	Ancillary services	230,697,971	36,177,536	266,875,507	18.00
19.00	Outpatient services	0	1,396,578	1,396,578	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	PHYSICIAN REVENUE	0	36,743	36,743	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. line 1)	398,717,571	37,610,857	436,328,428	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		89,369,917		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)		89,369,917		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN:14-2011

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

Worksheet G-3

Date/Time Prepared:
11/29/2021 12:20 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	436,328,428	1.00
2.00	Less contractual allowances and discounts on patients' accounts	357,380,654	2.00
3.00	Net patient revenues (line 1 minus line 2)	78,947,774	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	89,369,917	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-10,422,143	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	60,077	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	132,780	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	5,985	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	INTERCOMPANY RENTAL	0	24.00
24.01	NET ASSETS RELEASED	8,841	24.01
24.02	OTHER REVENUE	1,066,579	24.02
24.50	COVID-19 PHE Funding	-1,552	24.50
25.00	Total other income (sum of lines 6-24)	1,272,710	25.00
26.00	Total (line 5 plus line 25)	-9,149,433	26.00
27.00	OTHER NON OPERATING ACTIVITY	12,600	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	12,600	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-9,162,033	29.00