

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

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-3027	Period: From 09/01/2018 To 08/31/2019	Worksheet S Parts I-III Date/Time Prepared: 1/27/2020 3:26 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 1/27/2020	Time: 3:26 pm
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MARIANJOY REHAB HOSPITAL & CLINIC (14-3027) for the cost reporting period beginning 09/01/2018 and ending 08/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-450,351	384	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	Total	0	-450,351	384	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019Worksheet S-2
Part I
Date/Time Prepared:
1/27/2020 3:26 pm

1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 26W171 ROOSEVELT ROAD			PO Box:						1.00		
2.00	City: WHEATON			State: IL		Zip Code: 60187		County: DUPAGE		2.00		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
								V	XVIII	XIX		
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		MARIANOJOY REHAB HOSPITAL & CLINIC		143027	16974	5	01/01/1973	N	P	P	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF		MARIANOJOY REHAB HOSPITAL & CLINIC		146129	16974		12/18/2008	N	P	N	9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:	To:				
							1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)						09/01/2018		08/31/2019		20.00	
21.00	Type of Control (see instructions)						2				21.00	
							1.00	2.00		3.00		
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N			23.00		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
				1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	0	0	0	0	0		24.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-3027		Period: From 09/01/2018 To 08/31/2019		Worksheet S-2 Part I Date/Time Prepared: 1/27/2020 3:26 pm		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
				1.00	2.00	3.00	4.00	5.00	6.00	
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.			959	767	0	0	979		25.00
							Urban/Rural S	Date of Geogr		
							1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						1			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						1			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0			35.00
							Beginning:	Ending:		
							1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.									36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.						0			37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)									37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.									38.00
							Y/N	Y/N		
							1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)						N	N		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)						N	N		40.00
							V	XVIII	XIX	
							1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital										
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)						N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.						N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.						N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.						N	N	N	48.00
Teaching Hospitals										
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.						Y			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.						N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.						N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.						N			59.00
						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 §413.85? (see instructions)						N			60.00

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From 09/01/2018
To 08/31/2019Worksheet S-2
Part I
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1/27/2020 3:26 pm

	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00		2.00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
	Unweighted FTEs Nonprovider Site		Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
	1.00		2.00	3.00		
64.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

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	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		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
			1.00	2.00	5.00			
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00		
					1.00	2.00	3.00	
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.				Y		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)				Y	N	0	76.00

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				1.00			
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00		
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00		
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00		
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00		
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00		
			V	XIX			
			1.00	2.00			
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N	98.06	
Rural Providers							
105.00	Does this hospital qualify as a CAH?			N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.					107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108.00	
			Physical	Occupational	Speech	Respiratory	
			1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			N	N	N	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-3027	Period: From 09/01/2018 To 08/31/2019	Worksheet S-2 Part I Date/Time Prepared: 1/27/2020 3:26 pm	
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
			1.00	2.00	3.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	116,234	55,851	864,238	118.01
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				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		HB0640	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-3027		Period: From 09/01/2018 To 08/31/2019		Worksheet S-2 Part I Date/Time Prepared: 1/27/2020 3:26 pm		
1.00		2.00		3.00						
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.										
141.00	Name: NORTHWESTERN MEMORIAL HEALTHCARE		Contractor's Name: NGS		Contractor's Number: 00450				141.00	
142.00	Street: 251 E HURON STREET		PO Box:						142.00	
143.00	City: CHICAGO		State: IL		Zip Code: 60611				143.00	
								1.00		
144.00	Are provider based physicians' costs included in Worksheet A?								Y	144.00
								1.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				Y		N		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N				146.00	
								1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital			N	N	N	N		155.00	
156.00	Subprovider - IPF			N	N	N	N		156.00	
157.00	Subprovider - IRF			N	N	N	N		157.00	
158.00	SUBPROVIDER								158.00	
159.00	SNF			N	N	N	N		159.00	
160.00	HOME HEALTH AGENCY			N	N	N	N		160.00	
161.00	CMHC				N	N	N		161.00	
								1.00		
Multicampus										
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00
				Name	County	State	Zip Code	CBSA	FTE/Campus	
				0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00	
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								0	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
						Beginning	Ending			
						1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00	
						1.00	2.00			
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N		0	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-3027	Period: From 09/01/2018 To 08/31/2019	Worksheet S-2 Part II Date/Time Prepared: 1/27/2020 3:26 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)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	12/16/2019	Y 12/16/2019
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019Worksheet S-2
Part II
Date/Time Prepared:
1/27/2020 3:26 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				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BRANDON	HOFMANN		41.00
42.00	Enter the employer/company name of the cost report preparer.	NORTHWESTERN MEMORIAL HEALTHCARE			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	815-766-7529	BRANDON.HOMFANN@NM.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019Worksheet S-2
Part II
Date/Time Prepared:
1/27/2020 3:26 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.	SENIOR FINANCIAL ANALYST	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: 14-3027

Period:
From 09/01/2018
To 08/31/2019Worksheet S-3
Part I
Date/Time Prepared:
1/27/2020 3:26 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	100	36,500	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)		100	36,500	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		100	36,500	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	44.00	27	9,855		0	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)		127			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019Worksheet S-3
Part I
Date/Time Prepared:
1/27/2020 3:26 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)	17,103	1,726	34,419			1.00
2.00	HMO and other (see instructions)	2,890	979				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)	17,103	1,726	34,419			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)	17,103	1,726	34,419	11.02	511.60	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	4,006	0	6,137	0.00	25.09	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				11.02	536.69	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: 14-3027

Period:
From 09/01/2018
To 08/31/2019Worksheet S-3
Part I
Date/Time Prepared:
1/27/2020 3:26 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	1,283	110	2,380	1.00
2.00 HMO and other (see instructions)			201	64		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,283	110	2,380	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019

Worksheet S-7

Date/Time Prepared:
1/27/2020 3:26 pm

		1.00	2.00	3.00	4.00
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N			2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	0	0	3.00
4.00		RUL	0	0	4.00
5.00		RVX	0	0	5.00
6.00		RVL	0	0	6.00
7.00		RHX	0	0	7.00
8.00		RHL	0	0	8.00
9.00		RMX	0	0	9.00
10.00		RML	0	0	10.00
11.00		RLX	0	0	11.00
12.00		RUC	14	0	14 12.00
13.00		RUB	228	0	228 13.00
14.00		RUA	3,530	0	3,530 14.00
15.00		RVC	0	0	0 15.00
16.00		RVB	18	0	18 16.00
17.00		RVA	161	0	161 17.00
18.00		RHC	0	0	0 18.00
19.00		RHB	0	0	0 19.00
20.00		RHA	2	0	2 20.00
21.00		RMC	0	0	0 21.00
22.00		RMB	0	0	0 22.00
23.00		RMA	3	0	3 23.00
24.00		RLB	0	0	0 24.00
25.00		RLA	0	0	0 25.00
26.00		ES3	0	0	0 26.00
27.00		ES2	0	0	0 27.00
28.00		ES1	0	0	0 28.00
29.00		HE2	0	0	0 29.00
30.00		HE1	0	0	0 30.00
31.00		HD2	0	0	0 31.00
32.00		HD1	0	0	0 32.00
33.00		HC2	0	0	0 33.00
34.00		HC1	0	0	0 34.00
35.00		HB2	0	0	0 35.00
36.00		HB1	0	0	0 36.00
37.00		LE2	0	0	0 37.00
38.00		LE1	0	0	0 38.00
39.00		LD2	0	0	0 39.00
40.00		LD1	0	0	0 40.00
41.00		LC2	0	0	0 41.00
42.00		LC1	0	0	0 42.00
43.00		LB2	0	0	0 43.00
44.00		LB1	0	0	0 44.00
45.00		CE2	0	0	0 45.00
46.00		CE1	0	0	0 46.00
47.00		CD2	0	0	0 47.00
48.00		CD1	0	0	0 48.00
49.00		CC2	0	0	0 49.00
50.00		CC1	6	0	6 50.00
51.00		CB2	0	0	0 51.00
52.00		CB1	8	0	8 52.00
53.00		CA2	0	0	0 53.00
54.00		CA1	15	0	15 54.00
55.00		SE3	0	0	0 55.00
56.00		SE2	0	0	0 56.00
57.00		SE1	0	0	0 57.00
58.00		SSC	0	0	0 58.00
59.00		SSB	0	0	0 59.00
60.00		SSA	0	0	0 60.00
61.00		IB2	0	0	0 61.00
62.00		IB1	0	0	0 62.00
63.00		IA2	0	0	0 63.00
64.00		IA1	0	0	0 64.00
65.00		BB2	0	0	0 65.00
66.00		BB1	0	0	0 66.00
67.00		BA2	0	0	0 67.00
68.00		BA1	0	0	0 68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019

Worksheet S-7

Date/Time Prepared:
1/27/2020 3:26 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	1	0	1	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	6	0	6	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	14	0	14	199.00
200.00	TOTAL		4,006	0	4,006	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
SNF SERVICES						
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).			16974		201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		2,272,871	18.26	Y	202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	ALL OTHER APPLICABLE EXPENSE		128,358	1.03	Y	206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		12,447,563			207.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019

Worksheet A

Date/Time Prepared:
1/27/2020 3:26 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		4,135,796	4,135,796	-1,005,331	3,130,465	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	1,005,331	1,005,331	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	807,295	131,734	939,029	9,980,905	10,919,934	4.00
5.01	00590	A&G NON INTERN & NON RESIDENT	2,257,905	5,252,007	7,509,912	-907,039	6,602,873	5.01
5.02	00560	A&G PURCHASING & RECEIVING	170,190	152,381	322,571	-32,616	289,955	5.02
5.03	00570	A&G ADMITTING	1,442,386	383,021	1,825,407	-356,270	1,469,137	5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE	0	0	0	0	0	5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED	3,355,017	10,195,133	13,550,150	-1,020,510	12,529,640	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	25,665	3,995,426	4,021,091	-760,663	3,260,428	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	847,289	851,013	1,698,302	-362,592	1,335,710	9.00
10.00	01000	DIETARY	1,294,466	1,631,767	2,926,233	-1,398,007	1,528,226	10.00
11.00	01100	CAFETERIA	0	0	0	937,547	937,547	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	521,448	139,959	661,407	-111,926	549,481	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	254,632	319,685	574,317	-110,597	463,720	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	375,245	118,269	493,514	-84,774	408,740	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	843,237	843,237	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	21,835	8,818	30,653	-7,110	23,543	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,237,799	663,333	1,901,132	-322,790	1,578,342	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	1,116	1,116	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,777,991	4,970,170	17,748,161	-3,754,030	13,994,131	30.00
44.00	04400	SKILLED NURSING FACILITY	1,800,477	600,752	2,401,229	-545,592	1,855,637	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	72,071	55,357	127,428	269,565	396,993	54.00
60.00	06000	LABORATORY	0	152,813	152,813	340,452	493,265	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	224,035	105,432	329,467	-78,937	250,530	65.00
66.00	06600	PHYSICAL THERAPY	2,507,570	722,562	3,230,132	-690,408	2,539,724	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,769,322	446,824	2,216,146	-429,397	1,786,749	67.00
68.00	06800	SPEECH PATHOLOGY	1,764,661	404,350	2,169,011	-388,542	1,780,469	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	142,620	142,620	61,192	203,812	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,148,201	1,009,957	2,158,158	-257,485	1,900,673	73.00
74.00	07400	RENAL DIALYSIS	0	297,271	297,271	0	297,271	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	2,193,255	649,921	2,843,176	-351,364	2,491,812	90.01
90.02	09002	OTHER DAY HOSPITAL	1,614,461	481,360	2,095,821	-380,068	1,715,753	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	38,483,216	38,017,731	76,500,947	83,297	76,584,244	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	73,215	15,181	88,396	-9,012	79,384	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	91,431	347,789	439,220	-74,285	364,935	191.01
200.00		TOTAL (SUM OF LINES 118 through 199)	38,647,862	38,380,701	77,028,563	0	77,028,563	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019

Worksheet A

Date/Time Prepared:
1/27/2020 3:26 pm

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-861,789	2,268,676	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-193,302	812,029	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-903	10,919,031	4.00
5.01	00590	A&G NON INTERN & NON RESIDENT	-3,087,622	3,515,251	5.01
5.02	00560	A&G PURCHASING & RECEIVING	-531	289,424	5.02
5.03	00570	A&G ADMITTING	-7,100	1,462,037	5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE	0	0	5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED	-69,872	12,459,768	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-844,252	2,416,176	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	8.00
9.00	00900	HOUSEKEEPING	0	1,335,710	9.00
10.00	01000	DIETARY	0	1,528,226	10.00
11.00	01100	CAFETERIA	-606,059	331,488	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	-2,425	547,056	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-8,883	454,837	14.00
15.00	01500	PHARMACY	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-65	408,675	16.00
17.00	01700	SOCIAL SERVICE	0	843,237	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	23,543	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	-282,224	1,296,118	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	1,116	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-338,128	13,656,003	30.00
44.00	04400	SKILLED NURSING FACILITY	-72	1,855,565	44.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	396,993	54.00
60.00	06000	LABORATORY	0	493,265	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	-131	250,399	65.00
66.00	06600	PHYSICAL THERAPY	-54,567	2,485,157	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,786,749	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,780,469	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	954	204,766	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-103	1,900,570	73.00
74.00	07400	RENAL DIALYSIS	0	297,271	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	WHEATON OUTPATIENT	-1,710	2,490,102	90.01
90.02	09002	OTHER DAY HOSPITAL	-2,801	1,712,952	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-6,361,585	70,222,659	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	79,384	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	-471	364,464	191.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-6,362,056	70,666,507	200.00

RECLASSIFICATIONS

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019Worksheet A-6
Date/Time Prepared:
1/27/2020 3:26 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	506,475	431,072		1.00
	TOTALS		506,475	431,072		
	B - MEDICAL SUPPLIES CHARGED TO PATIENTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	61,192		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
	TOTALS		0	61,192		
	C - PATIENT SCHEDULING					
1.00	ADULTS & PEDIATRICS	30.00	396,029	7,538		1.00
2.00	PHYSICAL THERAPY	66.00	1,372	26		2.00
3.00	SPEECH PATHOLOGY	68.00	258	5		3.00
4.00	WHEATON OUTPATIENT	90.01	34,790	662		4.00
5.00	OTHER DAY HOSPITAL	90.02	24,554	467		5.00
	TOTALS		457,003	8,698		
	D - STAFF RECLASS					
1.00	SOCIAL SERVICE	17.00	843,237	0		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		843,237	0		
	E - CROSS DEPARTMENT RECLASS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	286,159	0		1.00
2.00	LABORATORY	60.00	340,452	0		2.00
	TOTALS		626,611	0		
	F - RENTED SPACE RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	23,338		1.00
2.00	A&G NON INTERN & NON RESIDENT	5.01	0	85,643		2.00
3.00	A&G PURCHASING & RECEIVING	5.02	0	7,274		3.00
4.00	A&G OTHER INTERN & RESIDENT RELATED	5.05	0	217,793		4.00
5.00	OPERATION OF PLANT	7.00	0	76,115		5.00
6.00	HOUSEKEEPING	9.00	0	27,279		6.00
7.00	DIETARY	10.00	0	69,560		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	30,537		8.00
9.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	10,419		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	53,913		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,001		11.00
12.00	OCCUPATIONAL THERAPY	67.00	0	1,326		12.00
13.00	SPEECH PATHOLOGY	68.00	0	1,894		13.00
14.00	WHEATON OUTPATIENT	90.01	0	210,424		14.00
15.00	RESEARCH	191.00	0	6,062		15.00
	TOTALS		0	826,578		
	G - LIBRARY					
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	428	0		1.00
2.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	1,116		2.00
	TOTALS		428	1,116		
	H - BENEFITS RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	9,957,567		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
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

RECLASSIFICATIONS

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019

Worksheet A-6

Date/Time Prepared:
1/27/2020 3:26 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
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	9,957,567		
	I - DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,005,331		1.00
	TOTALS		0	1,005,331		
500.00	Grand Total: Increases		2,433,754	12,291,554		500.00

RECLASSIFICATIONS

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019Worksheet A-6
Date/Time Prepared:
1/27/2020 3:26 pm

	Decreases						1/27/2020 3:26 pm
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	506,475	431,072	0		1.00
	TOTALS		506,475	431,072			
	B - MEDICAL SUPPLIES CHARGED TO PATIENTS						
1.00	ADULTS & PEDIATRICS	30.00	0	19,197	0		1.00
2.00	SKILLED NURSING FACILITY	44.00	0	2,881	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	18,090	0		3.00
4.00	SPEECH PATHOLOGY	68.00	0	15	0		4.00
5.00	DRUGS CHARGED TO PATIENTS	73.00	0	21,004	0		5.00
6.00	WHEATON OUTPATIENT	90.01	0	5	0		6.00
	TOTALS		0	61,192			
	C - PATIENT SCHEDULING						
1.00	A&G NON INTERN & NON RESIDENT	5.01	457,003	8,698	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	TOTALS		457,003	8,698			
	D - STAFF RECLASS						
1.00	A&G OTHER INTERN & RESIDENT RELATED	5.05	652,622	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	266	0	0		2.00
3.00	SKILLED NURSING FACILITY	44.00	70,317	0	0		3.00
4.00	WHEATON OUTPATIENT	90.01	78,631	0	0		4.00
5.00	OTHER DAY HOSPITAL	90.02	41,401	0	0		5.00
	TOTALS		843,237	0			
	E - CROSS DEPARTMENT RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	626,611	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		626,611	0			
	F - RENTED SPACE RECLASS						
1.00	OPERATION OF PLANT	7.00	0	826,578	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
	TOTALS		0	826,578			
	G - LIBRARY						
1.00	A&G NON INTERN & NON RESIDENT	5.01	428	1,116	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		428	1,116			
	H - BENEFITS RECLASS						
1.00	A&G NON INTERN & NON RESIDENT	5.01	0	525,437	0		1.00
2.00	A&G PURCHASING & RECEIVING	5.02	0	39,890	0		2.00
3.00	A&G ADMITTING	5.03	0	356,270	0		3.00
4.00	A&G OTHER INTERN & RESIDENT RELATED	5.05	0	585,681	0		4.00
5.00	OPERATION OF PLANT	7.00	0	10,200	0		5.00
6.00	HOUSEKEEPING	9.00	0	389,871	0		6.00
7.00	DIETARY	10.00	0	530,020	0		7.00
8.00	NURSING ADMINISTRATION	13.00	0	111,926	0		8.00
9.00	CENTRAL SERVICES & SUPPLY	14.00	0	110,597	0		9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	115,311	0		10.00
11.00	OTHER GENERAL SERVICE (SPECIFY)	18.00	0	7,110	0		11.00
12.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	333,637	0		12.00
13.00	ADULTS & PEDIATRICS	30.00	0	3,565,436	0		13.00
14.00	SKILLED NURSING FACILITY	44.00	0	472,394	0		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	21,595	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	60,847	0		16.00

RECLASSIFICATIONS

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019

Worksheet A-6

Date/Time Prepared:
1/27/2020 3:26 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
17.00	PHYSICAL THERAPY	66.00	0	691,806	0	17.00
18.00	OCCUPATIONAL THERAPY	67.00	0	430,723	0	18.00
19.00	SPEECH PATHOLOGY	68.00	0	390,684	0	19.00
20.00	DRUGS CHARGED TO PATIENTS	73.00	0	236,481	0	20.00
21.00	WHEATON OUTPATIENT	90.01	0	518,604	0	21.00
22.00	OTHER DAY HOSPITAL	90.02	0	363,688	0	22.00
23.00	RESEARCH	191.00	0	15,074	0	23.00
24.00	CONTRACT MNGMT & JOINT	191.01	0	74,285	0	24.00
	VENTURE					
	TOTALS		0	9,957,567		
	I - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,005,331	9	1.00
	TOTALS		0	1,005,331		
500.00	Grand Total: Decreases		2,433,754	12,291,554		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019Worksheet A-7
Part I
Date/Time Prepared:
1/27/2020 3:26 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
			1.00	2.00	3.00			4.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	6,800,000	0	0	0	0	1.00	
2.00	Land Improvements	0	0	0	0	0	2.00	
3.00	Buildings and Fixtures	62,517,222	4,639,073	0	4,639,073	123,440	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	6,441,589	898,897	0	898,897	381,469	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	75,758,811	5,537,970	0	5,537,970	504,909	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	75,758,811	5,537,970	0	5,537,970	504,909	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	6,800,000	0					1.00
2.00	Land Improvements	0	0					2.00
3.00	Buildings and Fixtures	67,032,855	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	6,959,017	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	80,791,872	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	80,791,872	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019Worksheet A-7
Part II
Date/Time Prepared:
1/27/2020 3:26 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	4,135,796	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)	4,135,796	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		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	4,135,796				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	4,135,796				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019Worksheet A-7
Part III
Date/Time Prepared:
1/27/2020 3:26 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	67,032,855	0	67,032,855	0.905949	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,959,017	0	6,959,017	0.094051	0	2.00
3.00	Total (sum of lines 1-2)	73,991,872	0	73,991,872	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	2,268,676	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	812,029	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,080,705	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	2,268,676	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	812,029	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	3,080,705	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019

Worksheet A-8

Date/Time Prepared:
1/27/2020 3:26 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-300,502			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	263,884			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-606,059	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-65	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019

Worksheet A-8

Date/Time Prepared:
1/27/2020 3:26 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.00	OPERATING REVENUE	B	-94,439	A&G NON INTERN & NON RESIDENT	5.01	0	33.00
33.01	OPERATING REVENUE	B	-57,851	A&G OTHER INTERN & RESIDENT RELATED	5.05	0	33.01
33.02	OPERATING REVENUE	B	-833,171	OPERATION OF PLANT	7.00	0	33.02
33.03	OPERATING REVENUE	B	-278,575	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	33.03
33.04	OPERATING REVENUE	B	-25,359	ADULTS & PEDIATRICS	30.00	0	33.04
33.05	OPERATING REVENUE	B	-52,304	PHYSICAL THERAPY	66.00	0	33.05
33.06	OPERATING REVENUE	B	954	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	33.06
33.07	OPERATING REVENUE	B	-625	WHEATON OUTPATIENT	90.01	0	33.07
33.08	OPERATING REVENUE	B	-2,185	OTHER DAY HOSPITAL	90.02	0	33.08
34.00	IDPA ASSESSMENTS	A	-2,714,688	A&G NON INTERN & NON RESIDENT	5.01	0	34.00
34.01	TRANSPORTATION EXPENSE	A	-264,410	A&G NON INTERN & NON RESIDENT	5.01	0	34.01
34.02	TRANSPORTATION EXPENSE	A	-616	OTHER DAY HOSPITAL	90.02	0	34.02
34.03	FUNDRAISING	A	-3,137	A&G NON INTERN & NON RESIDENT	5.01	0	34.03
34.04	LOBBYING	A	-10,418	A&G NON INTERN & NON RESIDENT	5.01	0	34.04
34.05	SPECIAL PURPOSE FUND/FOUNDATION	A	-483	A&G OTHER INTERN & RESIDENT RELATED	5.05	0	34.05
34.06	SPECIAL PURPOSE FUND/FOUNDATION	A	-191,856	A&G OTHER INTERN & RESIDENT RELATED	5.05	0	34.06
34.07	DISPOSAL WRITE OFF	A	-51,349	CAP REL COSTS-BLDG & FIXT	1.00	9	34.07
34.08	DISPOSAL WRITE OFF	A	-11,346	OPERATION OF PLANT	7.00	0	34.08
34.09	DISPOSAL WRITE OFF	A	-4,107	ADULTS & PEDIATRICS	30.00	0	34.09
34.10	DISPOSAL WRITE OFF	A	-2,103	PHYSICAL THERAPY	66.00	0	34.10
34.11	REAL ESTATE TAXES	A	-7,080	A&G OTHER INTERN & RESIDENT RELATED	5.05	0	34.11
34.12	REAL ESTATE TAXES	A	265	OPERATION OF PLANT	7.00	0	34.12
34.13	SCHOLARSHIPS	A	-56,250	A&G OTHER INTERN & RESIDENT RELATED	5.05	0	34.13
34.14	NONALLOWABLE EXPENSES	A	-29	A&G OTHER INTERN & RESIDENT RELATED	5.05	0	34.14
34.15	SALES TAX EXPENSES	A	-49	CENTRAL SERVICES & SUPPLY	14.00	0	34.15
34.16	MISC EXPENSE	A	-903	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.16
34.17	MISC EXPENSE	A	-530	A&G NON INTERN & NON RESIDENT	5.01	0	34.17
34.18	MISC EXPENSE	A	-792	A&G ADMITTING	5.03	0	34.18
34.19	MISC EXPENSE	A	-9,135	A&G OTHER INTERN & RESIDENT RELATED	5.05	0	34.19
34.20	MISC EXPENSE	A	-8,630	CENTRAL SERVICES & SUPPLY	14.00	0	34.20
34.21	MISC EXPENSE	A	-2,414	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	34.21
34.22	MISC EXPENSE	A	-1,323	ADULTS & PEDIATRICS	30.00	0	34.22
34.23	MISC EXPENSE	A	-36	PHYSICAL THERAPY	66.00	0	34.23
34.24	MISC EXPENSE	A	-103	DRUGS CHARGED TO PATIENTS	73.00	0	34.24
34.25	MISC EXPENSE	A	-823	WHEATON OUTPATIENT	90.01	0	34.25
34.26	MISC EXPENSE	A	-471	CONTRACT MNGMT & JOINT VENTURE	191.01	0	34.26
34.27	MARKETING	A	-531	A&G PURCHASING & RECEIVING	5.02	0	34.27
34.28	MARKETING	A	-6,308	A&G ADMITTING	5.03	0	34.28
34.29	MARKETING	A	-11,072	A&G OTHER INTERN & RESIDENT RELATED	5.05	0	34.29
34.30	MARKETING	A	-2,425	NURSING ADMINISTRATION	13.00	0	34.30
34.31	MARKETING	A	-204	CENTRAL SERVICES & SUPPLY	14.00	0	34.31
34.32	MARKETING	A	-1,235	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	34.32
34.33	MARKETING	A	-6,837	ADULTS & PEDIATRICS	30.00	0	34.33
34.34	MARKETING	A	-72	SKILLED NURSING FACILITY	44.00	0	34.34
34.35	MARKETING	A	-131	RESPIRATORY THERAPY	65.00	0	34.35
34.36	MARKETING	A	-124	PHYSICAL THERAPY	66.00	0	34.36
34.37	MARKETING	A	-262	WHEATON OUTPATIENT	90.01	0	34.37
34.38	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.38
34.39	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.39

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019

Worksheet A-8

Date/Time Prepared:
1/27/2020 3:26 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
35.00	MEDICARE DEPRECIATION	A	-810,440	CAP REL COSTS-BLDG & FIXT	1.00	9	35.00
36.00	MEDICARE DEPRECIATION	A	-193,302	CAP REL COSTS-MVBLE EQUIP	2.00	9	36.00
37.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	37.00
50.00	(3)						
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,362,056				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: 14-3027

Period:
From 09/01/2018
To 08/31/2019

Worksheet A-8-1

Date/Time Prepared:
1/27/2020 3:26 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	EMPLOYEE BENEFITS	7,292,198	7,292,198	1.00
2.00	5.05	A&G OTHER INTERN & RESIDENT	NMHC HOME OFFICE	9,111,661	8,847,777	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
4.01	5.01	A&G NON INTERN & NON RESIDENT	INSURANCE	751,577	751,577	4.01
4.02	21.00	I&R SERVICES-SALARY & FRINGE	PURCHASED SERVICE	200,000	200,000	4.02
4.03	30.00	ADULTS & PEDIATRICS	PHYSICIAN SERVICES	503,254	503,254	4.03
4.04	60.00	LABORATORY	CORPORATE EXPENSE	140,984	140,984	4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			17,999,674	17,735,790	5.00

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

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
	1.00	2.00	3.00	4.00	5.00

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

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

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

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

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

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

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

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019

Worksheet A-8-1

Date/Time Prepared:
1/27/2020 3:26 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	0	0		1.00
2.00	263,884	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
5.00	263,884			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		

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

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

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

6.00	MOTHER HOUSE		6.00
7.00	CORPORATE OFFIC		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: 14-3027

Period:
From 09/01/2018
To 08/31/2019

Worksheet A-8-2

Date/Time Prepared:
1/27/2020 3:26 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	30.00	ADULTS & PEDIATRICS	503,254	110,250	393,004	179,000	2,356	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			503,254	110,250	393,004		2,356	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	202,752	10,138	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			202,752	10,138	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	202,752	190,252	300,502		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	202,752	190,252	300,502		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019Worksheet B
Part I
Date/Time Prepared:
1/27/2020 3:26 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	A&G NON INTERN & NON RESIDENT	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	5.01
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,268,676	2,268,676			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	812,029		812,029		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	10,919,031	0	1,360	10,920,391	4.00
5.01	00590	A&G NON INTERN & NON RESIDENT	3,515,251	34,018	64,174	519,599	4,133,042
5.02	00560	A&G PURCHASING & RECEIVING	289,424	0	1,705	49,115	0
5.03	00570	A&G ADMITTING	1,462,037	27,723	3,681	416,258	0
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE	0	0	0	0	0
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED	12,459,768	38,701	13,215	779,884	0
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00	00700	OPERATION OF PLANT	2,416,176	190,863	143,629	7,407	0
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0
9.00	00900	HOUSEKEEPING	1,335,710	19,455	71,393	244,519	0
10.00	01000	DIETARY	1,528,226	80,764	21,646	227,406	0
11.00	01100	CAFETERIA	331,488	0	0	146,164	0
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	547,056	0	0	150,485	0
14.00	01400	CENTRAL SERVICES & SUPPLY	454,837	87,420	0	73,484	0
15.00	01500	PHARMACY	0	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	408,675	0	0	108,292	0
17.00	01700	SOCIAL SERVICE	843,237	0	0	243,350	0
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	23,543	10,047	0	6,301	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,296,118	0	0	357,340	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	1,116	0	0	0	0
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	13,656,003	1,283,677	174,960	3,620,962	1,487,358
44.00	04400	SKILLED NURSING FACILITY	1,855,565	216,779	0	499,307	443,756
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	396,993	0	28,903	103,382	76,872
60.00	06000	LABORATORY	493,265	0	0	98,251	141,616
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	250,399	0	1,596	64,654	49,931
66.00	06600	PHYSICAL THERAPY	2,485,157	107,820	15,991	724,056	486,534
67.00	06700	OCCUPATIONAL THERAPY	1,786,749	94,452	550	510,609	467,651
68.00	06800	SPEECH PATHOLOGY	1,780,469	28,682	37,578	509,338	358,550
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	204,766	0	0	0	35,474
73.00	07300	DRUGS CHARGED TO PATIENTS	1,900,570	40,896	49,161	331,359	569,139
74.00	07400	RENAL DIALYSIS	297,271	0	0	0	16,161
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	WHEATON OUTPATIENT	2,490,102	0	43,211	620,299	0
90.02	09002	OTHER DAY HOSPITAL	1,712,952	0	31,360	461,055	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	70,222,659	2,261,297	704,113	10,872,876	4,133,042
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,379	0	0	0
191.00	19100	RESEARCH	79,384	0	100,645	21,129	0
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	364,464	0	7,271	26,386	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	70,666,507	2,268,676	812,029	10,920,391	4,133,042

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			A&G PURCHASING & RECEIVING	A&G ADMITTING	A&G PFS CASHIER/ACCTS RECEIVABLE	Subtotal	A&G OTHER INTERN & RESIDENT RELATED	
			5.02	5.03	5.04	5A.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	00590	A&G NON INTERN & NON RESIDENT						5.01
5.02	00560	A&G PURCHASING & RECEIVING	340,244					5.02
5.03	00570	A&G ADMITTING	22	1,909,721				5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE	0	0	0			5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED	0	0	0	13,291,568	13,291,568	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	96	0	0	2,758,171	638,963	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	4	0	0	1,671,081	387,126	9.00
10.00	01000	DIETARY	1,081	0	0	1,859,123	430,688	10.00
11.00	01100	CAFETERIA	695	0	0	478,347	110,815	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	128	0	0	697,669	161,623	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,233	0	0	623,974	144,551	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	516,967	119,762	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	1,086,587	251,721	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	39,891	9,241	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	213	0	0	1,653,671	383,093	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	1,116	259	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	118,126	595,534	0	20,936,620	4,850,195	30.00
44.00	04400	SKILLED NURSING FACILITY	21,718	177,689	0	3,214,814	744,750	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	12	30,781	0	636,943	147,555	54.00
60.00	06000	LABORATORY	3,356	56,706	0	793,194	183,753	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	4,814	19,993	0	391,387	90,669	65.00
66.00	06600	PHYSICAL THERAPY	2,295	200,552	0	4,022,405	931,838	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,351	187,257	0	3,049,619	706,481	67.00
68.00	06800	SPEECH PATHOLOGY	1,874	144,650	0	2,861,141	662,818	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	18,915	14,205	0	273,360	63,327	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	146,652	227,895	0	3,265,672	756,532	73.00
74.00	07400	RENAL DIALYSIS	0	6,471	0	319,903	74,109	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	6,685	145,381	0	3,305,678	765,800	90.01
90.02	09002	OTHER DAY HOSPITAL	2,974	102,607	0	2,310,948	535,359	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	340,244	1,909,721	0	70,059,849	13,151,028	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	7,379	1,709	190.00
191.00	19100	RESEARCH	0	0	0	201,158	46,601	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	0	0	398,121	92,230	191.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	340,244	1,909,721	0	70,666,507	13,291,568	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	A&G NON INTERN & NON RESIDENT						5.01
5.02	00560	A&G PURCHASING & RECEIVING						5.02
5.03	00570	A&G ADMITTING						5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE						5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED						5.05
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	3,397,134				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0			8.00
9.00	00900	HOUSEKEEPING	0	33,423	0	2,091,630		9.00
10.00	01000	DIETARY	0	138,753	0	86,280	2,514,844	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	150,188	0	93,391	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
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	17,261	0	10,733	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	2,205,367	0	1,371,345	2,134,294	30.00
44.00	04400	SKILLED NURSING FACILITY	0	372,427	0	231,584	380,550	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	185,235	0	115,183	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	162,268	0	100,902	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	49,275	0	30,640	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	70,260	0	43,689	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,384,457	0	2,083,747	2,514,844	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,677	0	7,883	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	0	0	0	0	191.01
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	3,397,134	0	2,091,630	2,514,844	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-3027

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Cost Center Description			CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	A&G NON INTERN & NON RESIDENT						5.01
5.02	00560	A&G PURCHASING & RECEIVING						5.02
5.03	00570	A&G ADMITTING						5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE						5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED						5.05
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	589,162					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	7,534	0	866,826			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,684	0	0	1,021,788		14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,258	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	15,843	0	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	537	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	25,563	0	0	659	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	274,102	0	866,826	365,774	0	30.00
44.00	04400	SKILLED NURSING FACILITY	34,163	0	0	67,250	0	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,527	0	0	36	0	54.00
60.00	06000	LABORATORY	7,100	0	0	10,393	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	4,673	0	0	14,907	0	65.00
66.00	06600	PHYSICAL THERAPY	52,668	0	0	7,108	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	31,449	0	0	7,278	0	67.00
68.00	06800	SPEECH PATHOLOGY	27,174	0	0	5,802	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	58,568	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,983	0	0	454,103	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	37,045	0	0	20,701	0	90.01
90.02	09002	OTHER DAY HOSPITAL	26,239	0	0	9,209	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	586,542	0	866,826	1,021,788	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	1,042	0	0	0	0	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	1,578	0	0	0	0	191.01
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)	589,162	0	866,826	1,021,788	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			16.00	17.00	18.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	A&G NON INTERN & NON RESIDENT						5.01
5.02	00560	A&G PURCHASING & RECEIVING						5.02
5.03	00570	A&G ADMITTING						5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE						5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED						5.05
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	645,987					16.00
17.00	01700	SOCIAL SERVICE	0	1,354,151				17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	77,663			18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	201,419	1,354,151	77,663	0	0	30.00
44.00	04400	SKILLED NURSING FACILITY	60,109	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,413	0	0	0	0	54.00
60.00	06000	LABORATORY	19,183	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	6,763	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	67,844	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	63,346	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	48,933	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,805	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,093	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,189	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	49,180	0	0	0	0	90.01
90.02	09002	OTHER DAY HOSPITAL	34,710	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	645,987	1,354,151	77,663	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	0	0	0	0	191.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	645,987	1,354,151	77,663	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	A&G NON INTERN & NON RESIDENT						5.01
5.02	00560	A&G PURCHASING & RECEIVING						5.02
5.03	00570	A&G ADMITTING						5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE						5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED						5.05
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
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)						18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	2,062,986					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		1,375				22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,062,986	1,375	0	36,702,117	-2,064,361	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	5,105,647	0	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	802,474	0	54.00
60.00	06000	LABORATORY	0	0	0	1,013,623	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	508,399	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,382,281	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	4,121,343	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,685,783	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	400,060	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,683,332	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	396,201	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	0	0	0	4,178,404	0	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	0	2,916,465	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,062,986	1,375	0	69,896,129	-2,064,361	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	29,648	0	190.00
191.00	19100	RESEARCH	0	0	0	248,801	0	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	0	0	491,929	0	191.01
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,062,986	1,375	0	70,666,507	-2,064,361	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00590	A&G NON INTERN & NON RESIDENT	5.01
5.02	00560	A&G PURCHASING & RECEIVING	5.02
5.03	00570	A&G ADMITTING	5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE	5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED	5.05
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
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
44.00	04400	SKILLED NURSING FACILITY	44.00
ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
90.01	09001	WHEATON OUTPATIENT	90.01
90.02	09002	OTHER DAY HOSPITAL	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
191.00	19100	RESEARCH	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	191.01
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-3027

Period:
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	1,360	1,360	4.00
5.01	00590	A&G NON INTERN & NON RESIDENT	129	34,018	64,174	65	5.01
5.02	00560	A&G PURCHASING & RECEIVING	17,985	0	1,705	19,690	5.02
5.03	00570	A&G ADMITTING	0	27,723	3,681	31,404	5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE	0	0	0	0	5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED	1,344,165	38,701	13,215	1,396,081	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	826,578	190,863	143,629	1,161,070	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	5,292	19,455	71,393	96,140	9.00
10.00	01000	DIETARY	28,648	80,764	21,646	131,058	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	2,555	0	0	2,555	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,513	87,420	0	93,933	14.00
15.00	01500	PHARMACY	0	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
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	10,047	0	10,047	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	54,789	1,283,677	174,960	1,513,426	30.00
44.00	04400	SKILLED NURSING FACILITY	4,972	216,779	0	221,751	44.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	28,903	28,903	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	3,728	0	1,596	5,324	65.00
66.00	06600	PHYSICAL THERAPY	7,042	107,820	15,991	130,853	66.00
67.00	06700	OCCUPATIONAL THERAPY	410	94,452	550	95,412	67.00
68.00	06800	SPEECH PATHOLOGY	186	28,682	37,578	66,446	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	83,859	0	0	83,859	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	906	40,896	49,161	90,963	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	WHEATON OUTPATIENT	934	0	43,211	44,145	90.01
90.02	09002	OTHER DAY HOSPITAL	2,213	0	31,360	33,573	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,390,904	2,261,297	704,113	5,356,314	1,354
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,379	0	7,379	190.00
191.00	19100	RESEARCH	0	0	100,645	100,645	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	2,039	0	7,271	9,310	191.01
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,392,943	2,268,676	812,029	5,473,648	1,360

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Cost Center Description		A&G NON INTERN & NON RESIDENT	A&G PURCHASING & RECEIVING	A&G ADMITTING	A&G PFS CASHIER/ACCTS RECEIVABLE	A&G OTHER INTERN & RESIDENT RELATED	
		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	00590	A&G NON INTERN & NON RESIDENT	98,386				5.01
5.02	00560	A&G PURCHASING & RECEIVING	0	19,696			5.02
5.03	00570	A&G ADMITTING	0	1	31,457		5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE	0	0	0	0	5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED	0	0	0	1,396,178	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	6	0	67,117	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	40,664	9.00
10.00	01000	DIETARY	0	63	0	45,240	10.00
11.00	01100	CAFETERIA	0	40	0	11,640	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	7	0	16,977	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	477	0	15,184	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	12,580	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	26,441	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	971	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	12	0	40,240	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	27	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	35,378	6,838	9,821	0	30.00
44.00	04400	SKILLED NURSING FACILITY	10,568	1,257	2,925	0	44.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,831	1	507	0	54.00
60.00	06000	LABORATORY	3,373	194	934	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,189	279	329	0	65.00
66.00	06600	PHYSICAL THERAPY	11,587	133	3,302	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,137	136	3,083	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,539	108	2,381	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	845	1,095	234	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,554	8,490	3,752	0	73.00
74.00	07400	RENAL DIALYSIS	385	0	107	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	WHEATON OUTPATIENT	0	387	2,393	0	90.01
90.02	09002	OTHER DAY HOSPITAL	0	172	1,689	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	98,386	19,696	31,457	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	180	190.00
191.00	19100	RESEARCH	0	0	0	4,895	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	0	0	9,688	191.01
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)	98,386	19,696	31,457	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	A&G NON INTERN & NON RESIDENT						5.01
5.02	00560	A&G PURCHASING & RECEIVING						5.02
5.03	00570	A&G ADMITTING						5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE						5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED						5.05
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	1,228,194				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0			8.00
9.00	00900	HOUSEKEEPING	0	12,084	0	148,919		9.00
10.00	01000	DIETARY	0	50,165	0	6,143	232,697	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	54,299	0	6,649	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
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	6,240	0	764	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	797,324	0	97,636	197,485	30.00
44.00	04400	SKILLED NURSING FACILITY	0	134,647	0	16,488	35,212	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66,969	0	8,201	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	58,666	0	7,184	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	17,815	0	2,182	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	25,402	0	3,111	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,223,611	0	148,358	232,697	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,583	0	561	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	0	0	0	0	191.01
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	1,228,194	0	148,919	232,697	202.00

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Cost Center Description			CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	A&G NON INTERN & NON RESIDENT						5.01
5.02	00560	A&G PURCHASING & RECEIVING						5.02
5.03	00570	A&G ADMITTING						5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE						5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED						5.05
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	11,698					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	150	0	19,708			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	192	0	0	170,743		14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	184	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	315	0	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	11	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	508	0	0	110	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,441	0	19,708	61,122	0	30.00
44.00	04400	SKILLED NURSING FACILITY	678	0	0	11,238	0	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	149	0	0	6	0	54.00
60.00	06000	LABORATORY	141	0	0	1,737	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	93	0	0	2,491	0	65.00
66.00	06600	PHYSICAL THERAPY	1,046	0	0	1,188	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	624	0	0	1,216	0	67.00
68.00	06800	SPEECH PATHOLOGY	540	0	0	970	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	9,787	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	317	0	0	75,880	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	736	0	0	3,459	0	90.01
90.02	09002	OTHER DAY HOSPITAL	521	0	0	1,539	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,646	0	19,708	170,743	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	21	0	0	0	0	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	31	0	0	0	0	191.01
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)	11,698	0	19,708	170,743	0	202.00

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Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
		16.00	17.00	18.00	19.00	20.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	A&G NON INTERN & NON RESIDENT					5.01
5.02	00560	A&G PURCHASING & RECEIVING					5.02
5.03	00570	A&G ADMITTING					5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE					5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED					5.05
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	12,778				16.00
17.00	01700	SOCIAL SERVICE	0	26,786			17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	18,034		18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,939	26,786	18,034		30.00
44.00	04400	SKILLED NURSING FACILITY	1,195	0	0		44.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	207	0	0		54.00
60.00	06000	LABORATORY	381	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	134	0	0		65.00
66.00	06600	PHYSICAL THERAPY	1,349	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,259	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	973	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	96	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,533	0	0		73.00
74.00	07400	RENAL DIALYSIS	44	0	0		74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0	0		76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	WHEATON OUTPATIENT	978	0	0		90.01
90.02	09002	OTHER DAY HOSPITAL	690	0	0		90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,778	26,786	18,034	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0		191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	0	0		191.01
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)	12,778	26,786	18,034	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	A&G NON INTERN & NON RESIDENT						5.01
5.02	00560	A&G PURCHASING & RECEIVING						5.02
5.03	00570	A&G ADMITTING						5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE						5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED						5.05
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
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)						18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	40,915					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		27				22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				3,302,875	0	30.00
44.00	04400	SKILLED NURSING FACILITY				514,250	0	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC				47,116	0	54.00
60.00	06000	LABORATORY				26,074	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
65.00	06500	RESPIRATORY THERAPY				19,371	0	65.00
66.00	06600	PHYSICAL THERAPY				322,599	0	66.00
67.00	06700	OCCUPATIONAL THERAPY				252,990	0	67.00
68.00	06800	SPEECH PATHOLOGY				169,641	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				102,568	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS				302,510	0	73.00
74.00	07400	RENAL DIALYSIS				8,321	0	74.00
76.97	07697	CARDIAC REHABILITATION				0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				0	0	76.98
76.99	07699	LITHOTRIPSY				0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT				132,615	0	90.01
90.02	09002	OTHER DAY HOSPITAL				94,477	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	5,295,407	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				12,703	0	190.00
191.00	19100	RESEARCH				105,564	0	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE				19,032	0	191.01
200.00		Cross Foot Adjustments	40,915	27	0	40,942	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	40,915	27	0	5,473,648	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019Worksheet B
Part II
Date/Time Prepared:
1/27/2020 3:26 pm

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00590	A&G NON INTERN & NON RESIDENT	5.01
5.02	00560	A&G PURCHASING & RECEIVING	5.02
5.03	00570	A&G ADMITTING	5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE	5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED	5.05
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
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
44.00	04400	SKILLED NURSING FACILITY	44.00
ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
90.01	09001	WHEATON OUTPATIENT	90.01
90.02	09002	OTHER DAY HOSPITAL	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
191.00	19100	RESEARCH	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	191.01
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019

Worksheet B-1

Date/Time Prepared:
1/27/2020 3:26 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	A&G NON INTERN & NON RESIDENT (INPATIENT REVENUE)	A&G PURCHASING & RECEIVING (ALLOCATION 1)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	163,260					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		771,916				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,293	37,840,567			4.00
5.01	00590	A&G NON INTERN & NON RESIDENT	2,448	61,004	1,800,474	115,933,775		5.01
5.02	00560	A&G PURCHASING & RECEIVING	0	1,621	170,190	0	1,531,015	5.02
5.03	00570	A&G ADMITTING	1,995	3,499	1,442,386	0	100	5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE	0	0	0	0	0	5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED	2,785	12,562	2,702,395	0	0	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	13,735	136,534	25,665	0	431	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,400	67,866	847,289	0	18	9.00
10.00	01000	DIETARY	5,812	20,577	787,991	0	4,866	10.00
11.00	01100	CAFETERIA	0	0	506,475	0	3,128	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	521,448	0	574	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,291	0	254,632	0	37,047	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	375,245	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	843,237	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	723	0	21,835	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	1,238,227	0	958	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	92,377	166,317	12,547,143	41,721,008	531,538	30.00
44.00	04400	SKILLED NURSING FACILITY	15,600	0	1,730,160	12,447,563	97,727	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	27,475	358,230	2,156,302	53	54.00
60.00	06000	LABORATORY	0	0	340,452	3,972,394	15,103	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,517	224,035	1,400,593	21,663	65.00
66.00	06600	PHYSICAL THERAPY	7,759	15,201	2,508,942	13,647,524	10,329	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,797	523	1,769,322	13,117,834	10,577	67.00
68.00	06800	SPEECH PATHOLOGY	2,064	35,722	1,764,919	10,057,516	8,432	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	995,076	85,111	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,943	46,733	1,148,201	15,964,637	659,895	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	453,328	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	0	41,076	2,149,414	0	30,083	90.01
90.02	09002	OTHER DAY HOSPITAL	0	29,811	1,597,614	0	13,382	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	162,729	669,331	37,675,921	115,933,775	1,531,015	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	531	0	0	0	0	190.00
191.00	19100	RESEARCH	0	95,673	73,215	0	0	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	6,912	91,431	0	0	191.01
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)	2,268,676	812,029	10,920,391	4,133,042	340,244	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.896092	1.051965	0.288590	0.035650	0.222234	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			1,360	98,386	19,696	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000036	0.000849	0.012865	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: 14-3027

Period:
From 09/01/2018
To 08/31/2019

Worksheet B-1

Date/Time Prepared:
1/27/2020 3:26 pm

Cost Center Description			A&G ADMITTING (GROSS REVENUE)	A&G PFS CASHIER/ACCTS RECEIVABLE (INPATIENT REVENUE)	Reconciliation	A&G OTHER INTERN & RESIDENT RELATED (ACCUM COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
			5.03	5.04	5A.05	5.05	6.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	A&G NON INTERN & NON RESIDENT						5.01
5.02	00560	A&G PURCHASING & RECEIVING						5.02
5.03	00570	A&G ADMITTING	133,783,257					5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE	0	115,933,775				5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED	0	0	-13,291,568	57,374,939		5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	156,032	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	2,758,171	13,735	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	1,671,081	1,400	9.00
10.00	01000	DIETARY	0	0	0	1,859,123	5,812	10.00
11.00	01100	CAFETERIA	0	0	0	478,347	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	697,669	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	623,974	6,291	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	516,967	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	1,086,587	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	39,891	723	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	1,653,671	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	1,116	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	41,721,008	41,721,008	0	20,936,620	92,377	30.00
44.00	04400	SKILLED NURSING FACILITY	12,447,563	12,447,563	0	3,214,814	15,600	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,156,302	2,156,302	0	636,943	0	54.00
60.00	06000	LABORATORY	3,972,394	3,972,394	0	793,194	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,400,593	1,400,593	0	391,387	0	65.00
66.00	06600	PHYSICAL THERAPY	14,049,196	13,647,524	0	4,022,405	7,759	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,117,834	13,117,834	0	3,049,619	6,797	67.00
68.00	06800	SPEECH PATHOLOGY	10,133,081	10,057,516	0	2,861,141	2,064	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	995,076	995,076	0	273,360	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,964,637	15,964,637	0	3,265,672	2,943	73.00
74.00	07400	RENAL DIALYSIS	453,328	453,328	0	319,903	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	10,184,334	0	0	3,305,678	0	90.01
90.02	09002	OTHER DAY HOSPITAL	7,187,911	0	0	2,310,948	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	133,783,257	115,933,775	-13,291,568	56,768,281	155,501	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	7,379	531	190.00
191.00	19100	RESEARCH	0	0	0	201,158	0	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	0	0	398,121	0	191.01
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)	1,909,721	0		13,291,568	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.014275	0.000000		0.231662	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	31,457	0		1,396,178	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000235	0.000000		0.024334	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: 14-3027

Period:
From 09/01/2018
To 08/31/2019

Worksheet B-1

Date/Time Prepared:
1/27/2020 3:26 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	A&G NON INTERN & NON RESIDENT					5.01
5.02	00560	A&G PURCHASING & RECEIVING					5.02
5.03	00570	A&G ADMITTING					5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE					5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED					5.05
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT	142,297				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0			8.00
9.00	00900	HOUSEKEEPING	1,400	0	140,897		9.00
10.00	01000	DIETARY	5,812	0	5,812	40,556	10.00
11.00	01100	CAFETERIA	0	0	0	864,944	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	11,061	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,291	0	6,291	0	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	13,592	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	23,259	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	723	0	723	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	37,529	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	92,377	0	92,377	34,419	30.00
44.00	04400	SKILLED NURSING FACILITY	15,600	0	15,600	6,137	44.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	11,051	54.00
60.00	06000	LABORATORY	0	0	0	10,424	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,861	65.00
66.00	06600	PHYSICAL THERAPY	7,759	0	7,759	77,322	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,797	0	6,797	46,170	67.00
68.00	06800	SPEECH PATHOLOGY	2,064	0	2,064	39,894	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,943	0	2,943	23,464	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	WHEATON OUTPATIENT	0	0	0	54,386	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	0	38,521	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	141,766	0	140,366	40,556	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	531	0	531	0	190.00
191.00	19100	RESEARCH	0	0	0	1,530	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	0	0	2,317	191.01
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)	3,397,134	0	2,091,630	2,514,844	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.873546	0.000000	14.845100	62.009173	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,228,194	0	148,919	232,697	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	8.631201	0.000000	1.056935	5.737671	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: 14-3027

Period:
From 09/01/2018
To 08/31/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (ALLOCATION 2)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
			12.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	A&G NON INTERN & NON RESIDENT						5.01
5.02	00560	A&G PURCHASING & RECEIVING						5.02
5.03	00570	A&G ADMITTING						5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE						5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0					12.00
13.00	01300	NURSING ADMINISTRATION	0	1,000				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,484,851			14.00
15.00	01500	PHARMACY	0	0	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	133,783,257	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	958	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	1,000	531,538	0	41,721,008	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	97,727	0	12,447,563	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	53	0	2,156,302	54.00
60.00	06000	LABORATORY	0	0	15,103	0	3,972,394	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	21,663	0	1,400,593	65.00
66.00	06600	PHYSICAL THERAPY	0	0	10,329	0	14,049,196	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	10,577	0	13,117,834	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	8,432	0	10,133,081	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	85,111	0	995,076	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	659,895	0	15,964,637	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	453,328	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	0	0	30,083	0	10,184,334	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	13,382	0	7,187,911	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,000	1,484,851	0	133,783,257	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	0	0	0	0	191.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	866,826	1,021,788	0	645,987	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	866.826000	0.688142	0.000000	0.004829	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	19,708	170,743	0	12,778	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	19.708000	0.114990	0.000000	0.000096	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: 14-3027

Period:
From 09/01/2018
To 08/31/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE (SPECIFY) (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			17.00	18.00	19.00	20.00	21.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	A&G NON INTERN & NON RESIDENT						5.01
5.02	00560	A&G PURCHASING & RECEIVING						5.02
5.03	00570	A&G ADMITTING						5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE						5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED						5.05
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	1,000					17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	1,000				18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			1,000	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,000	1,000	0	0	1,000	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
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
76.97	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								
90.01	09001	WHEATON OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,000	1,000	0	0	1,000	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	0	0	0	0	191.01
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)	1,354,151	77,663	0	0	2,062,986	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1,354.151000	77.663000	0.000000	0.000000	2,062.986000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	26,786	18,034	0	0	40,915	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	26.786000	18.034000	0.000000	0.000000	40.915000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHER PRGM COSTS		
			APPRV (ASSIGNED TIME)		
			22.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00590	A&G NON INTERN & NON RESIDENT			5.01
5.02	00560	A&G PURCHASING & RECEIVING			5.02
5.03	00570	A&G ADMITTING			5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE			5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED			5.05
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
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)			18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	1,000		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,000	0	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
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					
90.01	09001	WHEATON OUTPATIENT	0	0	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,000	0	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	0	191.01
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)	1,375	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.375000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	27	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.027000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019Worksheet C
Part I
Date/Time Prepared:
1/27/2020 3:26 pm

			Title XVIII		Hospital		PPS		
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs			
						RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	34,637,756		34,637,756	190,252	34,828,008	30.00	
44.00	04400	SKILLED NURSING FACILITY	5,105,647		5,105,647	0	5,105,647	44.00	
	ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	802,474		802,474	0	802,474	54.00	
60.00	06000	LABORATORY	1,013,623		1,013,623	0	1,013,623	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	508,399	0	508,399	0	508,399	65.00	
66.00	06600	PHYSICAL THERAPY	5,382,281	0	5,382,281	0	5,382,281	66.00	
67.00	06700	OCCUPATIONAL THERAPY	4,121,343	0	4,121,343	0	4,121,343	67.00	
68.00	06800	SPEECH PATHOLOGY	3,685,783	0	3,685,783	0	3,685,783	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	400,060		400,060	0	400,060	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	4,683,332		4,683,332	0	4,683,332	73.00	
74.00	07400	RENAL DIALYSIS	396,201		396,201	0	396,201	74.00	
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99	
	OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	4,178,404		4,178,404	0	4,178,404	90.01	
90.02	09002	OTHER DAY HOSPITAL	2,916,465		2,916,465	0	2,916,465	90.02	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00	
200.00		Subtotal (see instructions)	67,831,768	0	67,831,768	190,252	68,022,020	200.00	
201.00		Less Observation Beds	0		0		0	201.00	
202.00		Total (see instructions)	67,831,768	0	67,831,768	190,252	68,022,020	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019Worksheet C
Part I
Date/Time Prepared:
1/27/2020 3:26 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	41,721,008		41,721,008			30.00
44.00	04400	SKILLED NURSING FACILITY	12,447,563		12,447,563			44.00
	ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,156,302	0	2,156,302	0.372153	0.000000	54.00
60.00	06000	LABORATORY	3,972,394	0	3,972,394	0.255167	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	1,400,593	0	1,400,593	0.362988	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	13,647,524	401,672	14,049,196	0.383102	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,117,834	0	13,117,834	0.314179	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	10,057,516	75,565	10,133,081	0.363738	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	995,076	0	995,076	0.402040	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,964,637	0	15,964,637	0.293357	0.000000	73.00
74.00	07400	RENAL DIALYSIS	453,328	0	453,328	0.873983	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	09001	WHEATON OUTPATIENT	0	10,184,334	10,184,334	0.410278	0.000000	90.01
90.02	09002	OTHER DAY HOSPITAL	0	7,187,911	7,187,911	0.405746	0.000000	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
200.00		Subtotal (see instructions)	115,933,775	17,849,482	133,783,257			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	115,933,775	17,849,482	133,783,257			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019Worksheet C
Part I
Date/Time Prepared:
1/27/2020 3:26 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
44.00	04400 SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.372153			54.00
60.00	06000 LABORATORY	0.255167			60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500 RESPIRATORY THERAPY	0.362988			65.00
66.00	06600 PHYSICAL THERAPY	0.383102			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.314179			67.00
68.00	06800 SPEECH PATHOLOGY	0.363738			68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.402040			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.293357			73.00
74.00	07400 RENAL DIALYSIS	0.873983			74.00
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699 LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	09001 WHEATON OUTPATIENT	0.410278			90.01
90.02	09002 OTHER DAY HOSPITAL	0.405746			90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019Worksheet C
Part I
Date/Time Prepared:
1/27/2020 3:26 pm

			Title XIX		Hospital		PPS		
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs			
						RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	36,702,117		36,702,117	190,252	36,892,369	30.00	
44.00	04400	SKILLED NURSING FACILITY	5,105,647		5,105,647	0	5,105,647	44.00	
	ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	802,474		802,474	0	802,474	54.00	
60.00	06000	LABORATORY	1,013,623		1,013,623	0	1,013,623	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	508,399	0	508,399	0	508,399	65.00	
66.00	06600	PHYSICAL THERAPY	5,382,281	0	5,382,281	0	5,382,281	66.00	
67.00	06700	OCCUPATIONAL THERAPY	4,121,343	0	4,121,343	0	4,121,343	67.00	
68.00	06800	SPEECH PATHOLOGY	3,685,783	0	3,685,783	0	3,685,783	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	400,060		400,060	0	400,060	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	4,683,332		4,683,332	0	4,683,332	73.00	
74.00	07400	RENAL DIALYSIS	396,201		396,201	0	396,201	74.00	
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99	
	OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	4,178,404		4,178,404	0	4,178,404	90.01	
90.02	09002	OTHER DAY HOSPITAL	2,916,465		2,916,465	0	2,916,465	90.02	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00	
200.00		Subtotal (see instructions)	69,896,129	0	69,896,129	190,252	70,086,381	200.00	
201.00		Less Observation Beds	0		0		0	201.00	
202.00		Total (see instructions)	69,896,129	0	69,896,129	190,252	70,086,381	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019Worksheet C
Part I
Date/Time Prepared:
1/27/2020 3:26 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	0		0			30.00	
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00	
	ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00	
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98	
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99	
	OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	0	0	0	0.000000	0.000000	90.01	
90.02	09002	OTHER DAY HOSPITAL	0	0	0	0.000000	0.000000	90.02	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00	
200.00		Subtotal (see instructions)	0	0	0			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	0	0	0			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019Worksheet C
Part I
Date/Time Prepared:
1/27/2020 3:26 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
44.00	04400 SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400 RENAL DIALYSIS	0.000000			74.00
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699 LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	09001 WHEATON OUTPATIENT	0.000000			90.01
90.02	09002 OTHER DAY HOSPITAL	0.000000			90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

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

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019Worksheet C
Part II
Date/Time Prepared:
1/27/2020 3:26 pm

Cost Center Description		Title XIX		Hospital		PPS	
		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	
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	802,474	47,116	755,358	0	0 54.00
60.00	06000	LABORATORY	1,013,623	26,074	987,549	0	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	508,399	19,371	489,028	0	0 65.00
66.00	06600	PHYSICAL THERAPY	5,382,281	322,599	5,059,682	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	4,121,343	252,990	3,868,353	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	3,685,783	169,641	3,516,142	0	0 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	400,060	102,568	297,492	0	0 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,683,332	302,510	4,380,822	0	0 73.00
74.00	07400	RENAL DIALYSIS	396,201	8,321	387,880	0	0 74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	WHEATON OUTPATIENT	4,178,404	132,615	4,045,789	0	0 90.01
90.02	09002	OTHER DAY HOSPITAL	2,916,465	94,477	2,821,988	0	0 90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0 92.00
200.00		Subtotal (sum of lines 50 thru 199)	28,088,365	1,478,282	26,610,083	0	0 200.00
201.00		Less Observation Beds	0	0	0	0	0 201.00
202.00		Total (line 200 minus line 201)	28,088,365	1,478,282	26,610,083	0	0 202.00

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

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019

Worksheet C
Part II
Date/Time Prepared:
1/27/2020 3:26 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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	802,474	2,156,302	0.372153	54.00
60.00	06000	LABORATORY	1,013,623	3,972,394	0.255167	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	508,399	1,400,593	0.362988	65.00
66.00	06600	PHYSICAL THERAPY	5,382,281	14,049,196	0.383102	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,121,343	13,117,834	0.314179	67.00
68.00	06800	SPEECH PATHOLOGY	3,685,783	10,133,081	0.363738	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	400,060	995,076	0.402040	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,683,332	15,964,637	0.293357	73.00
74.00	07400	RENAL DIALYSIS	396,201	453,328	0.873983	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS						
90.01	09001	WHEATON OUTPATIENT	4,178,404	10,184,334	0.410278	90.01
90.02	09002	OTHER DAY HOSPITAL	2,916,465	7,187,911	0.405746	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	92.00
200.00		Subtotal (sum of lines 50 thru 199)	28,088,365	79,614,686		200.00
201.00		Less Observation Beds	0	0		201.00
202.00		Total (line 200 minus line 201)	28,088,365	79,614,686		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019Worksheet D
Part I
Date/Time Prepared:
1/27/2020 3:26 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	3,302,875	0	3,302,875	34,419	95.96	30.00
44.00	SKILLED NURSING FACILITY	514,250		514,250	6,137	83.80	44.00
200.00	Total (lines 30 through 199)	3,817,125		3,817,125	40,556		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	17,103	1,641,204				
44.00	SKILLED NURSING FACILITY	4,006	335,703				
200.00	Total (lines 30 through 199)	21,109	1,976,907				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019Worksheet D
Part II
Date/Time Prepared:
1/27/2020 3:26 pm

Cost Center Description			Title XVIII		Hospital	PPS	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	47,116	2,156,302	0.021850	1,188,534	25,969
60.00	06000	LABORATORY	26,074	3,972,394	0.006564	2,141,940	14,060
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0
65.00	06500	RESPIRATORY THERAPY	19,371	1,400,593	0.013831	694,675	9,608
66.00	06600	PHYSICAL THERAPY	322,599	14,049,196	0.022962	6,988,065	160,460
67.00	06700	OCCUPATIONAL THERAPY	252,990	13,117,834	0.019286	6,722,163	129,644
68.00	06800	SPEECH PATHOLOGY	169,641	10,133,081	0.016741	5,243,671	87,784
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	102,568	995,076	0.103076	564,655	58,202
73.00	07300	DRUGS CHARGED TO PATIENTS	302,510	15,964,637	0.018949	7,556,797	143,194
74.00	07400	RENAL DIALYSIS	8,321	453,328	0.018355	185,583	3,406
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	WHEATON OUTPATIENT	132,615	10,184,334	0.013021	0	0
90.02	09002	OTHER DAY HOSPITAL	94,477	7,187,911	0.013144	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0
200.00		Total (lines 50 through 199)	1,478,282	79,614,686		31,286,083	632,327

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-3027		Period: From 09/01/2018 To 08/31/2019		Worksheet D Part III Date/Time Prepared: 1/27/2020 3:26 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	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	0	44.00	
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	34,419	0.00	17,103	0.00	17,103	30.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	6,137	0.00	4,006	0.00	4,006	44.00	
200.00		Total (lines 30 through 199)	0	0	40,556		21,109		21,109	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
44.00	04400	SKILLED NURSING FACILITY	0								44.00
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019Worksheet D
Part IV
Date/Time Prepared:
1/27/2020 3:26 pm

Cost Center Description			Title XVIII		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
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
76.97	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								
90.01	09001	WHEATON OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019

Worksheet D
Part IV
Date/Time Prepared:
1/27/2020 3:26 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)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,156,302	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	3,972,394	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,400,593	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	14,049,196	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	13,117,834	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	10,133,081	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	995,076	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	15,964,637	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	453,328	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	0	0	0	10,184,334	0.000000	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	0	7,187,911	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	79,614,686		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-3027		Period: From 09/01/2018 To 08/31/2019		Worksheet D Part IV Date/Time Prepared: 1/27/2020 3:26 pm	
Cost Center Description				Title XVIII		Hospital		PPS	
				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									
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		1,188,534	0	0	0	54.00
60.00	06000	LABORATORY	0.000000		2,141,940	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000		694,675	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000		6,988,065	0	3,930	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		6,722,163	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		5,243,671	0	38,448	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		564,655	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		7,556,797	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000		185,583	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000		0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000		0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	WHEATON OUTPATIENT	0.000000		0	0	0	0	90.01
90.02	09002	OTHER DAY HOSPITAL	0.000000		0	0	3	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)			31,286,083	0	42,381	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019Worksheet D
Part V
Date/Time Prepared:
1/27/2020 3:26 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							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.372153	0	0	0	0	54.00
60.00	06000	LABORATORY	0.255167	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.362988	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.383102	3,930	0	0	1,506	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.314179	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.363738	38,448	0	0	13,985	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.402040	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.293357	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.873983	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	09001	WHEATON OUTPATIENT	0.410278	0	0	0	0	90.01
90.02	09002	OTHER DAY HOSPITAL	0.405746	3	0	0	1	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Subtotal (see instructions)		42,381	0	0	15,492	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		42,381	0	0	15,492	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-3027		Period: From 09/01/2018 To 08/31/2019		Worksheet D Part V Date/Time Prepared: 1/27/2020 3:26 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									
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0				
60.00	06000	LABORATORY		0	0				
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0				
65.00	06500	RESPIRATORY THERAPY		0	0				
66.00	06600	PHYSICAL THERAPY		0	0				
67.00	06700	OCCUPATIONAL THERAPY		0	0				
68.00	06800	SPEECH PATHOLOGY		0	0				
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0				
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0				
74.00	07400	RENAL DIALYSIS		0	0				
76.97	07697	CARDIAC REHABILITATION		0	0				
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0				
76.99	07699	LITHOTRIPSY		0	0				
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	WHEATON OUTPATIENT		0	0				
90.02	09002	OTHER DAY HOSPITAL		0	0				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0				
200.00		Subtotal (see instructions)		0	0				
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0					
202.00		Net Charges (line 200 - line 201)		0	0				

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-3027 Component CCN: 14-6129		Period: From 09/01/2018 To 08/31/2019		Worksheet D Part IV Date/Time Prepared: 1/27/2020 3:26 pm	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
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
76.97	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									
90.01	09001	WHEATON OUTPATIENT		0	0	0	0	0	90.01
90.02	09002	OTHER DAY HOSPITAL		0	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-3027 Component CCN: 14-6129		Period: From 09/01/2018 To 08/31/2019		Worksheet D Part IV Date/Time Prepared: 1/27/2020 3:26 pm	
			Title XVIII		Skilled Nursing Facility		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)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,156,302	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	3,972,394	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,400,593	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	14,049,196	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	13,117,834	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	10,133,081	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	995,076	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	15,964,637	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	453,328	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	0	0	0	10,184,334	0.000000	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	0	7,187,911	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	79,614,686		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-3027 Component CCN: 14-6129		Period: From 09/01/2018 To 08/31/2019		Worksheet D Part IV Date/Time Prepared: 1/27/2020 3:26 pm	
				Title XVIII		Skilled Nursing Facility		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									
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	13,322	0	0	0	54.00
60.00	06000	LABORATORY		0.000000	295,925	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY		0.000000	120,027	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	1,521,913	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	1,380,204	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	212,143	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	74,768	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	1,365,486	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	WHEATON OUTPATIENT		0.000000	0	0	0	0	90.01
90.02	09002	OTHER DAY HOSPITAL		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)			4,983,788	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019Worksheet D
Part I
Date/Time Prepared:
1/27/2020 3:26 pm

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Hospital Total Patient Days	PPS 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		3,302,875	0	3,302,875	34,419	95.96	30.00
44.00	SKILLED NURSING FACILITY		514,250		514,250	6,137	83.80	44.00
200.00	Total (lines 30 through 199)		3,817,125		3,817,125	40,556		200.00
Cost Center Description			Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
			6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		1,726	165,627				
44.00	SKILLED NURSING FACILITY		0	0				
200.00	Total (lines 30 through 199)		1,726	165,627				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019Worksheet D
Part II
Date/Time Prepared:
1/27/2020 3:26 pm

Cost Center Description			Title XIX		Hospital	PPS	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	47,116	0	0.000000	0	0 54.00
60.00	06000	LABORATORY	26,074	0	0.000000	0	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	19,371	0	0.000000	0	0 65.00
66.00	06600	PHYSICAL THERAPY	322,599	0	0.000000	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	252,990	0	0.000000	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	169,641	0	0.000000	0	0 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	102,568	0	0.000000	0	0 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	302,510	0	0.000000	0	0 73.00
74.00	07400	RENAL DIALYSIS	8,321	0	0.000000	0	0 74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	WHEATON OUTPATIENT	132,615	0	0.000000	0	0 90.01
90.02	09002	OTHER DAY HOSPITAL	94,477	0	0.000000	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)	1,478,282	0		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-3027		Period: From 09/01/2018 To 08/31/2019		Worksheet D Part III Date/Time Prepared: 1/27/2020 3:26 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	0	0	0	0	30.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	0	44.00	
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	34,419	0.00	1,726	0	0	30.00	
44.00	04400	SKILLED NURSING FACILITY		0	6,137	0.00	0	0	0	44.00	
200.00		Total (lines 30 through 199)		0	40,556		1,726			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
44.00	04400	SKILLED NURSING FACILITY	0								44.00
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019Worksheet D
Part IV
Date/Time Prepared:
1/27/2020 3:26 pm

Cost Center Description			Title XIX		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
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
76.97	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								
90.01	09001	WHEATON OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-3027		Period: From 09/01/2018 To 08/31/2019		Worksheet D Part IV Date/Time Prepared: 1/27/2020 3:26 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)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0.000000	54.00
60.00	06000	LABORATORY		0	0	0	0	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	WHEATON OUTPATIENT		0	0	0	0	0.000000	90.01
90.02	09002	OTHER DAY HOSPITAL		0	0	0	0	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	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019Worksheet D
Part IV
Date/Time Prepared:
1/27/2020 3:26 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					
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
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								
90.01	09001	WHEATON OUTPATIENT	0.000000	0	0	0	0	90.01
90.02	09002	OTHER DAY HOSPITAL	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)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-3027	Period: From 09/01/2018 To 08/31/2019	Worksheet D-1 Date/Time Prepared: 1/27/2020 3:26 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)		34,419	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		34,419	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)		34,419	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)		17,103	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)		34,828,008	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)		34,828,008	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)		34,828,008	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)		1,011.88	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		17,306,184	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		17,306,184	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019

Worksheet D-1

Date/Time Prepared:
1/27/2020 3:26 pm

Cost Center Description		Title XVIII			Hospital	PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					10,543,502	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					27,849,686	49.00
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,641,204	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					632,327	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,273,531	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					25,576,155	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: 14-3027

Period:
From 09/01/2018
To 08/31/2019

Worksheet D-1

Date/Time Prepared:
1/27/2020 3:26 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	3,302,875	34,828,008	0.094834	0	0	90.00
91.00	Nursing School cost	0	34,828,008	0.000000	0	0	91.00
92.00	Allied health cost	0	34,828,008	0.000000	0	0	92.00
93.00	All other Medical Education	0	34,828,008	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-3027 Component CCN: 14-6129	Period: From 09/01/2018 To 08/31/2019	Worksheet D-1 Date/Time Prepared: 1/27/2020 3:26 pm
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,137	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,137	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		6,137	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)		4,006	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)		5,105,647	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)		5,105,647	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)		5,105,647	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-3027 Component CCN: 14-6129	Period: From 09/01/2018 To 08/31/2019	Worksheet D-1 Date/Time Prepared: 1/27/2020 3:26 pm	
				Title XVIII		Skilled Nursing Facility	PPS
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00			
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					5,105,647	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					831.95	71.00
72.00	Program routine service cost (line 9 x line 71)					3,332,792	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					3,332,792	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)					0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00	Inpatient routine service cost per diem limitation					0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)					3,332,792	83.00
84.00	Program inpatient ancillary services (see instructions)					1,648,514	84.00
85.00	Utilization review - physician compensation (see instructions)					0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					4,981,306	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: 14-3027

Period:

Worksheet D-1

Component CCN: 14-6129

From 09/01/2018
To 08/31/2019Date/Time Prepared:
1/27/2020 3:26 pm

Title XVIII

Skilled Nursing
Facility

PPS

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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-3027	Period: From 09/01/2018 To 08/31/2019	Worksheet D-1 Date/Time Prepared: 1/27/2020 3:26 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)		34,419	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		34,419	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)		34,419	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)		1,726	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)		36,892,369	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)		36,892,369	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)		36,892,369	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)		1,071.86	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,850,030	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)		1,850,030	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019

Worksheet D-1

Date/Time Prepared:
1/27/2020 3:26 pm

		Title XIX		Hospital	PPS		
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description						
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,850,030	49.00
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					165,627	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					165,627	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,684,403	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: 14-3027

Period:
From 09/01/2018
To 08/31/2019

Worksheet D-1

Date/Time Prepared:
1/27/2020 3:26 pm

Cost Center Description		Title XIX		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	3,302,875	36,892,369	0.089527	0	0 90.00
91.00	Nursing School cost	0	36,892,369	0.000000	0	0 91.00
92.00	Allied health cost	0	36,892,369	0.000000	0	0 92.00
93.00	All other Medical Education	0	36,892,369	0.000000	0	0 93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-3027	Period: From 09/01/2018 To 08/31/2019	Worksheet D-3 Date/Time Prepared: 1/27/2020 3:26 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		19,607,736		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.372153	1,188,534	442,316	54.00
60.00	06000 LABORATORY	0.255167	2,141,940	546,552	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.362988	694,675	252,159	65.00
66.00	06600 PHYSICAL THERAPY	0.383102	6,988,065	2,677,142	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.314179	6,722,163	2,111,962	67.00
68.00	06800 SPEECH PATHOLOGY	0.363738	5,243,671	1,907,322	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.402040	564,655	227,014	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.293357	7,556,797	2,216,839	73.00
74.00	07400 RENAL DIALYSIS	0.873983	185,583	162,196	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	09001 WHEATON OUTPATIENT	0.410278	0	0	90.01
90.02	09002 OTHER DAY HOSPITAL	0.405746	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)		31,286,083	10,543,502	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)		31,286,083		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-3027 Component CCN: 14-6129	Period: From 09/01/2018 To 08/31/2019	Worksheet D-3 Date/Time Prepared: 1/27/2020 3:26 pm	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.372153	13,322	4,958	54.00
60.00	06000 LABORATORY	0.255167	295,925	75,510	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.362988	120,027	43,568	65.00
66.00	06600 PHYSICAL THERAPY	0.383102	1,521,913	583,048	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.314179	1,380,204	433,631	67.00
68.00	06800 SPEECH PATHOLOGY	0.363738	212,143	77,164	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.402040	74,768	30,060	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.293357	1,365,486	400,575	73.00
74.00	07400 RENAL DIALYSIS	0.873983	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	09001 WHEATON OUTPATIENT	0.410278	0	0	90.01
90.02	09002 OTHER DAY HOSPITAL	0.405746	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)		4,983,788	1,648,514	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)		4,983,788		202.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
1/27/2020 3:26 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	0	0	0	0	0
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	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	282,853	4,079,211	4,362,064
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	0
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	0
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	0
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 aquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
1/27/2020 3:26 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
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				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
1/27/2020 3:26 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	0	0	0	0	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	282,853	4,079,211	4,362,064	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	0	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
1/27/2020 3:26 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: 14-3027	Period: From 09/01/2018 To 08/31/2019	Worksheet E Part B Date/Time Prepared: 1/27/2020 3:26 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		15,492	2.00
3.00	OPPS payments		6,303	3.00
4.00	Outlier payment (see instructions)		3,178	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.943	5.00
6.00	Line 2 times line 5		14,609	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		64.90	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		9,481	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)		1,339	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)		8,142	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		391	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)		8,533	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		8,533	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		8,533	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)			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)		8,533	40.00
40.01	Sequestration adjustment (see instructions)		171	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		7,978	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		384	43.00
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: 14-3027

Period:
From 09/01/2018
To 08/31/2019Worksheet E-1
Part I
Date/Time Prepared:
1/27/2020 3:26 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		30,782,302		7,978	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		786,826		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	04/03/2019	226,902		0	3.01
3.02		07/25/2019	56,222		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)		283,124		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)		31,852,252		7,978	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		384	6.01
6.02	SETTLEMENT TO PROGRAM		450,351		0	6.02
7.00	Total Medicare program liability (see instructions)		31,401,901		8,362	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

 Provider CCN: 14-3027
 Component CCN: 14-6129

 Period:
 From 09/01/2018
 To 08/31/2019

 Worksheet E-1
 Part I
 Date/Time Prepared:
 1/27/2020 3:26 pm

		Title XVIII		Skilled Nursing Facility	PPS
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider		2,124,517		0
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
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)				
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0
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)		2,124,517		0
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)				
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	SETTLEMENT TO PROVIDER		0		0
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		2,124,517		0
				Contractor Number	NPR Date (Mo/Day/Yr)
		0		1.00	2.00
8.00	Name of Contractor				

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-3027	Period: From 09/01/2018 To 08/31/2019	Worksheet E-3 Part III Date/Time Prepared: 1/27/2020 3:26 pm
		Title XVIII	Hospital	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)		26,920,078	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0.0043	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		689,154	3.00
4.00	Outlier Payments		663,260	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)		12.75	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	5.01
6.00	New Teaching program adjustment. (see instructions)		0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		11.02	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)		11.02	9.00
10.00	Average Daily Census (see instructions)		94.298630	10.00
11.00	Teaching Adjustment Factor (see instructions)		0.118877	11.00
12.00	Teaching Adjustment (see instructions)		3,200,178	12.00
13.00	Total PPS Payment (see instructions)		31,472,670	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)		0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		0	15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)		0	16.00
17.00	Subtotal (see instructions)		31,472,670	17.00
18.00	Primary payer payments		2,544	18.00
19.00	Subtotal (line 17 less line 18).		31,470,126	19.00
20.00	Deductibles		164,084	20.00
21.00	Subtotal (line 19 minus line 20)		31,306,042	21.00
22.00	Coinsurance		131,008	22.00
23.00	Subtotal (line 21 minus line 22)		31,175,034	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		38,551	24.00
25.00	Adjusted reimbursable bad debts (see instructions)		25,058	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		9,817	26.00
27.00	Subtotal (sum of lines 23 and 25)		31,200,092	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		842,664	28.00
29.00	Other pass through costs (see instructions)		0	29.00
30.00	Outlier payments reconciliation		0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS)		0	31.00
31.01	MSP PASS THROUGH		0	31.01
31.02	MSP LLC ADJUSTMENT		0	31.02
31.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	31.50
31.99	Demonstration payment adjustment amount before sequestration		0	31.99
32.00	Total amount payable to the provider (see instructions)		32,042,756	32.00
32.01	Sequestration adjustment (see instructions)		640,855	32.01
32.02	Demonstration payment adjustment amount after sequestration		0	32.02
33.00	Interim payments		31,852,252	33.00
34.00	Tentative settlement (for contractor use only)		0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)		-450,351	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		142,527	36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4		663,260	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		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-3027 Component CCN: 14-6129	Period: From 09/01/2018 To 08/31/2019	Worksheet E-3 Part VI Date/Time Prepared: 1/27/2020 3:26 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		2,216,782	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		2,216,782	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		48,908	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		2,167,874	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Demonstration payment adjustment amount before sequestration		0	14.99
15.00	Subtotal (see instructions)		2,167,874	15.00
15.01	Sequestration adjustment (see instructions)		43,357	15.01
15.02	Demonstration payment adjustment amount after sequestration		0	15.02
16.00	Interim payments		2,124,517	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)		0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-3027		Period: From 09/01/2018 To 08/31/2019		Worksheet E-4 Date/Time Prepared: 1/27/2020 3:26 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.			13.88		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			1.28		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)			12.60		5.00	
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			11.02		6.00	
7.00	Enter the lesser of line 5 or line 6			11.02		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	11.02	11.02		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	11.02	11.02		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	11.02	11.02		11.00	
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	13.85	13.85		12.00	
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	14.91	14.91		13.00	
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	13.26	13.26		14.00	
15.00	Adjustment for residents in initial years of new programs	0.00	0.00	0.00		15.00	
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00	0.00		15.01	
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00	0.00		16.00	
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00	0.00		16.01	
17.00	Adjusted rolling average FTE count	0.00	13.26	13.26		17.00	
18.00	Per resident amount	117,676.31	111,736.37	111,736.37		18.00	
19.00	Approved amount for resident costs	0	1,481,624	1,481,624		19.00	
				1.00			
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00		20.00	
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00		21.00	
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00		22.00	
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00		23.00	
24.00	Multiply line 22 time line 23			0		24.00	
25.00	Total direct GME amount (sum of lines 19 and 24)			1,481,624		25.00	
		Inpatient Part	Managed care				
		A					
		1.00	2.00	3.00			
COMPUTATION OF PROGRAM PATIENT LOAD							
26.00	Inpatient Days (see instructions)	17,103		2,890		26.00	
27.00	Total Inpatient Days (see instructions)	34,419		34,419		27.00	
28.00	Ratio of inpatient days to total inpatient days	0.496906		0.083965		28.00	
29.00	Program direct GME amount	736,228		124,405		29.00	
30.00	Reduction for direct GME payments for Medicare Advantage			17,578		30.00	
31.00	Net Program direct GME amount			843,055		31.00	

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-3027	Period: From 09/01/2018 To 08/31/2019	Worksheet E-4 Date/Time Prepared: 1/27/2020 3:26 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)		453,328	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)		33,399,260	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)		2,544	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		33,396,716	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		15,492	42.00
43.00	Primary payer payments (see instructions)		0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		15,492	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		33,412,208	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.999536	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.000464	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		843,055	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		842,664	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		391	50.00

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

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019

Worksheet G

Date/Time Prepared:
1/27/2020 3:26 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	21,007,909	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	11,226,867	0	0	0	4.00
5.00	Other receivable	-19,475	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	56,070	0	0	0	7.00
8.00	Prepaid expenses	180,807	0	0	0	8.00
9.00	Other current assets	802,303	0	0	0	9.00
10.00	Due from other funds	-176,572	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	33,077,909	0	0	0	11.00
FIXED ASSETS						
12.00	Land	6,800,000	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	67,032,855	0	0	0	15.00
16.00	Accumulated depreciation	-10,891,134	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	6,959,017	0	0	0	19.00
20.00	Accumulated depreciation	-2,976,242	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	66,924,496	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	5,380,565	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,380,565	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	105,382,970	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,274,303	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,301,699	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	2,224,459	0	0	0	43.00
44.00	Other current liabilities	1,910,876	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,711,337	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	5,799,283	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	5,799,283	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	15,510,620	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	89,872,350	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)	89,872,350	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	105,382,970	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019

Worksheet G-1

Date/Time Prepared:
1/27/2020 3:26 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		85,935,286		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,560,284				2.00
3.00	Total (sum of line 1 and line 2)		87,495,570		0		3.00
4.00	INTERCOMPANY SETTLEMENT	699,164		0		0	4.00
5.00	INTERCOMPANY SETTLEMENT	613,919		0		0	5.00
6.00	INTERCOMPANY SETTLEMENT	364,937		0		0	6.00
7.00	NET CAPITAL RELEASE	641,661		0		0	7.00
8.00	OTHER	57,099		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		2,376,780		0		10.00
11.00	Subtotal (line 3 plus line 10)		89,872,350		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)		89,872,350		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	INTERCOMPANY SETTLEMENT		0				4.00
5.00	INTERCOMPANY SETTLEMENT		0				5.00
6.00	INTERCOMPANY SETTLEMENT		0				6.00
7.00	NET CAPITAL RELEASE		0				7.00
8.00	OTHER		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: 14-3027

Period:
From 09/01/2018
To 08/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
1/27/2020 3:26 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	43,395,130		43,395,130	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	12,447,563		12,447,563	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)	55,842,693		55,842,693	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	55,842,693		55,842,693	17.00
18.00	Ancillary services	60,091,082	477,237	60,568,319	18.00
19.00	Outpatient services	0	17,372,245	17,372,245	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	OTHER OUTPATIENT INCOME	0	4,948,596	4,948,596	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	115,933,775	22,798,078	138,731,853	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		77,028,563		29.00
30.00	ROUNDING	2			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)		2		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)		77,028,565		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-3027

Period:
From 09/01/2018
To 08/31/2019

Worksheet G-3

Date/Time Prepared:
1/27/2020 3:26 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	138,731,853	1.00
2.00	Less contractual allowances and discounts on patients' accounts	64,482,753	2.00
3.00	Net patient revenues (line 1 minus line 2)	74,249,100	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	77,028,565	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,779,465	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	207,531	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	606,059	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	812,246	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	2,713,913	24.00
25.00	Total other income (sum of lines 6-24)	4,339,749	25.00
26.00	Total (line 5 plus line 25)	1,560,284	26.00
27.00	OTHER CONTRIBUTIONS	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,560,284	29.00