

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: 14-0130	Period: From 09/01/2019 To 08/31/2020	Worksheet S Parts I-III Date/Time Prepared: 3/26/2021 12:42 am
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 2. ☐ Manually prepared cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report 4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
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 NORTHWESTERN LAKE FOREST HOSPITAL (14-0130) for the cost reporting period beginning 09/01/2019 and ending 08/31/2020 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	-99,320	-39,573	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
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	-99,320	-39,573	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: 14-0130		Period: From 09/01/2019 To 08/31/2020		Worksheet S-2 Part I Date/Time Prepared: 3/26/2021 12:42 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 1000 WESTMORELAND ROAD			PO Box:				1.00	
2.00	City: LAKE FOREST			State: IL		Zip Code: 60045		County: LAKE 2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			NORTHWESTERN LAKE FOREST HOSPITAL	140130	29404	1	07/01/1966	N P O 3.00
4.00	Subprovider - IPF								4.00
5.00	Subprovider - IRF								5.00
6.00	Subprovider - (Other)								6.00
7.00	Swing Beds - SNF								7.00
8.00	Swing Beds - NF								8.00
9.00	Hospital-Based SNF								9.00
10.00	Hospital-Based NF								10.00
11.00	Hospital-Based OLTC								11.00
12.00	Hospital-Based HHA								12.00
13.00	Separately Certified ASC								13.00
14.00	Hospital-Based Hospice								14.00
15.00	Hospital-Based Health Clinic - RHC								15.00
16.00	Hospital-Based Health Clinic - FQHC								16.00
17.00	Hospital-Based (CMHC) I								17.00
18.00	Renal Dialysis								18.00
19.00	Other								19.00
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						09/01/2019	08/31/2020	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.					Y	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	Y		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.			1,820	1,043	0	19	3,813	0 24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020Worksheet S-2
Part I
Date/Time Prepared:
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		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.	0	0	0	0	0		25.00
						Urban/Rural S	Date of Geogr	
						1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
						Beginning:	Ending:	
						1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
						Y/N	Y/N	
						1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					Y	Y	40.00
						V	XVIII	XIX
						1.00	2.00	3.00
Prospective Payment System (PPS)-Capital								
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	Y	N
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals								
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					Y	Y	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		
					NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
					1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.					Y	Y	
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)						23.00	1

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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	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		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
			1.00	2.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
			1.00	2.00	3.00		
70.00	Inpatient Psychiatric Facility PPS						
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
	Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					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.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00	
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.				
		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: 14-0130

Period:
From 09/01/2019
To 08/31/2020Worksheet S-2
Part I
Date/Time Prepared:
3/26/2021 12:42 am

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
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:	574,881	1,353,003	3,901,354118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0640	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0130		Period: From 09/01/2019 To 08/31/2020		Worksheet S-2 Part I Date/Time Prepared: 3/26/2021 12:42 am	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name: NORTHWESTERN MEMORIAL HEALTHCARE AND		Contractor's Name: NGS		Contractor's Number: 06101		141.00		
142.00	Street: 251 E HURON ST		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?								N	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					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.							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.								Y	167.00
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)									168.00
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								0.01	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: 14-0130	Period: From 09/01/2019 To 08/31/2020	Worksheet S-2 Part II Date/Time Prepared: 3/26/2021 12:42 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	11/30/2020
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y		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.	Y		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.	Y		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	12/17/2020	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0130	Period: From 09/01/2019 To 08/31/2020	Worksheet S-2 Part II Date/Time Prepared: 3/26/2021 12:42 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
					1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
			1.00	2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JOHN	VANDER LAAN		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.	(312) 926-6618	JVANDERL@NM.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020Worksheet S-2
Part II
Date/Time Prepared:
3/26/2021 12:42 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020Worksheet S-3
Part I
Date/Time Prepared:
3/26/2021 12:42 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	110	40,260	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)		110	40,260	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,392	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		122	44,652	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	0	0		0	19.00
20.00 NURSING FACILITY	45.00	0	0		0	20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	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)		122			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)		8	2,928			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: 14-0130

Period:
From 09/01/2019
To 08/31/2020Worksheet S-3
Part I
Date/Time Prepared:
3/26/2021 12:42 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	10,014	2,209	29,212			1.00
2.00	HMO and other (see instructions)	2,646	3,813				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)	10,014	2,209	29,212			7.00
8.00	INTENSIVE CARE UNIT	2,603	87	3,762			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		466	4,001			13.00
14.00	Total (see instructions)	12,617	2,762	36,975	23.92	1,380.07	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	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY		0	0	0.00	0.00	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			74			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)				23.92	1,380.07	27.00
28.00	Observation Bed Days		0	7,399			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	120	569			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			142			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: 14-0130

Period:
From 09/01/2019
To 08/31/2020Worksheet S-3
Part I
Date/Time Prepared:
3/26/2021 12:42 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	3,165	716	9,503	1.00
2.00 HMO and other (see instructions)			562	1,190		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	3,165	716	9,503	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	0.00					20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					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

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020Worksheet S-3
Part II
Date/Time Prepared:
3/26/2021 12:42 am

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	107,708,079	0	107,708,079	2,828,237.00	38.08
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	1,522,355	0	1,522,355	50,758.00	29.99
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		496,393	21,938	518,331	14,911.00	34.76
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		5,924,926	0	5,924,926	72,247.00	82.01
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		1,364,454	0	1,364,454	7,224.00	188.88
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		29,700,839	0	29,700,839	687,626.00	43.19
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		27,543,060	0	27,543,060		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		148,844	0	148,844		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		3,567,422	0	3,567,422		
25.50	Home office wage-related (core)		2,589,207	0	2,589,207		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020Worksheet S-3
Part II
Date/Time Prepared:
3/26/2021 12:42 am

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	931,512	-841,459	90,053	4,298.00	20.95	26.00
27.00	Administrative & General	5.00	16,521,954	-3,136,979	13,384,975	301,731.00	44.36	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	4,056,678	0	4,056,678	146,935.00	27.61	30.00
31.00	Laundry & Linen Service	8.00	172,364	0	172,364	9,782.00	17.62	31.00
32.00	Housekeeping	9.00	2,447,078	0	2,447,078	136,496.00	17.93	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	133,470	0	133,470	4,390.00	30.40	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	487	0	487	24.00	20.29	37.00
38.00	Nursing Administration	13.00	6,425,022	381	6,425,403	135,979.00	47.25	38.00
39.00	Central Services and Supply	14.00	1,425,198	0	1,425,198	57,000.00	25.00	39.00
40.00	Pharmacy	15.00	3,036,264	0	3,036,264	64,346.00	47.19	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020Worksheet S-3
Part III
Date/Time Prepared:
3/26/2021 12:42 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	106,185,724	0	106,185,724	2,777,479.00	38.23	1.00
2.00	Excluded area salaries (see instructions)	496,393	21,938	518,331	14,911.00	34.76	2.00
3.00	Subtotal salaries (line 1 minus line 2)	105,689,331	-21,938	105,667,393	2,762,568.00	38.25	3.00
4.00	Subtotal other wages & related costs (see inst.)	36,990,219	0	36,990,219	767,097.00	48.22	4.00
5.00	Subtotal wage-related costs (see inst.)	30,132,267	0	30,132,267	0.00	28.52	5.00
6.00	Total (sum of lines 3 thru 5)	172,811,817	-21,938	172,789,879	3,529,665.00	48.95	6.00
7.00	Total overhead cost (see instructions)	35,150,027	-3,978,057	31,171,970	860,981.00	36.21	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020Worksheet S-3
Part IV
Date/Time Prepared:
3/26/2021 12:42 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	6,141,217	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	8,609,554	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	3,354,698	9.00
10.00	Dental, Hearing and Vision Plan	227,146	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	676,807	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	316,849	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	0	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	7,532,128	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	109,937	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	161,600	22.00
23.00	Tuition Reimbursement	413,124	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	27,543,060	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COST		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020Worksheet S-3
Part V
Date/Time Prepared:
3/26/2021 12:42 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	5,924,926	27,543,060	1.00
2.00	Hospital	5,924,926	27,543,060	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020

Worksheet S-5

Date/Time Prepared:
3/26/2021 12:42 am

		Outpatient		Training		Home		
		Regular	High Flux	Hemodialysis	CAPD / CCPD	Hemodialysis	CAPD / CCPD	
		1.00	2.00	3.00	4.00	5.00	6.00	
1.00	Number of patients in program at end of cost reporting period	0	0	0	0	0	0	1.00
2.00	Number of times per week patient receives dialysis	0.00	0.00	0.00	0.00	0.00	0.00	2.00
3.00	Average patient dialysis time including setup	0.00	0.00	0.00	0.00			3.00
4.00	CAPD exchanges per day				0.00		0.00	4.00
5.00	Number of days in year dialysis furnished	0	0					5.00
6.00	Number of stations	0	0	0	0			6.00
7.00	Treatment capacity per day per station	0	0					7.00
8.00	Utilization (see instructions)	0.00	0.00					8.00
9.00	Average times dialyzers re-used	0.00	0.00					9.00
10.00	Percentage of patients re-using dialyzers	0.00	0.00					10.00
							Y/N	
							1.00	
ESRD PPS								
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter "Y" for yes or "N" for no. (see instructions)						N	10.01
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter "Y" for yes or "N" for no. (See instructions for "new" providers.)						Y	10.02
						Prior to 1/1	After 12/31	
						1.00	2.00	
10.03	If you responded "N" to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)						0	4
TRANSPLANT INFORMATION								
11.00	Number of patients on transplant list						0	11.00
12.00	Number of patients transplanted during the cost reporting period						0	12.00
EPOETIN								
13.00	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider.							13.00
14.00	Epoetin amount from Worksheet A for Home Dialysis program							14.00
15.00	Number of EPO units furnished relating to the renal dialysis department							15.00
16.00	Number of EPO units furnished relating to the home dialysis department							16.00
ARANESP								
17.00	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider.							17.00
18.00	ARANESP amount from Worksheet A for Home Dialysis program							18.00
19.00	Number of ARANESP units furnished relating to the renal dialysis department							19.00
20.00	Number of ARANESP units furnished relating to the home dialysis department							20.00
						MCP	INITIAL METHOD	
						1.00	2.00	
PHYSICIAN PAYMENT METHOD								
21.00	Enter "X" if method(s) is applicable							21.00
		ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.		
		1.00	2.00	3.00	4.00	5.00		
ESAs								
22.00	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)		0	0	0	0	22.00	

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020

Worksheet S-5

Date/Time Prepared:
3/26/2021 12:42 am

		CCN	Treatments	
		1.00	2.00	
23.00	If line 10.01 is yes, enter in column 1 the CCN for each renal dialysis facility listed on Worksheet S-2, Part I, line 18, and its subscripts. Enter in column 2, the total treatments for each CCN. (see instructions)		0	23.00

Health Financial Systems		NORTHWESTERN LAKE FOREST HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0130	Period: From 09/01/2019 To 08/31/2020	Worksheet S-10	
				Date/Time Prepared: 3/26/2021 12:42 am	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.209750	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			23,466,809	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			1,098,606	5.00
6.00	Medicaid charges			227,015,028	6.00
7.00	Medicaid cost (line 1 times line 6)			47,616,402	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			23,050,987	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP			0	9.00
10.00	Stand-alone CHIP charges			0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care			80,211	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			23,050,987	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	60,063,453	1,434,513	61,497,966	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	12,598,309	1,434,513	14,032,822	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	12,598,309	1,434,513	14,032,822	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			18,085,984	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			544,931	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			838,356	27.01
28.00	Non-Medicare bad debt expense (see instructions)			17,247,628	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			3,911,115	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			17,943,937	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			40,994,924	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020

Worksheet A

Date/Time Prepared:
3/26/2021 12:42 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		22,446,145	22,446,145	0	22,446,145 1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		14,225,838	14,225,838	0	14,225,838 2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0 3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	931,512	445,472	1,376,984	18,861,436	20,238,420 4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,521,954	148,325,644	164,847,598	-8,712,598	156,135,000 5.00
7.00	00700	OPERATION OF PLANT	4,056,678	14,615,560	18,672,238	-1,009,608	17,662,630 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	172,364	1,010,210	1,182,574	-69,425	1,113,149 8.00
9.00	00900	HOUSEKEEPING	2,447,078	1,994,373	4,441,451	-958,743	3,482,708 9.00
10.00	01000	DIETARY	133,470	5,195,339	5,328,809	-2,615,457	2,713,352 10.00
11.00	01100	CAFETERIA	0	860,542	860,542	2,585,183	3,445,725 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	487	20,541	21,028	-170	20,858 12.00
13.00	01300	NURSING ADMINISTRATION	6,425,022	1,886,128	8,311,150	-978,488	7,332,662 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,425,198	1,873,534	3,298,732	-405,296	2,893,436 14.00
15.00	01500	PHARMACY	3,036,264	46,473,917	49,510,181	-48,549,257	960,924 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0 17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,522,355	316,158	1,838,513	0	1,838,513 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	90,337	536,511	626,848	-29,616	597,232 22.00
23.00	02300	PARAMED ED PRGM-(EMS)	0	0	0	78,138	78,138 23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	19,774,457	8,946,490	28,720,947	-41,901	28,679,046 30.00
31.00	03100	INTENSIVE CARE UNIT	3,701,935	3,617,294	7,319,229	-631,620	6,687,609 31.00
43.00	04300	NURSERY	918,117	1,003,299	1,921,416	831,265	2,752,681 43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0 45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	9,845,433	20,811,741	30,657,174	-14,371,933	16,285,241 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,461,407	1,469,527	3,930,934	-497,632	3,433,302 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,444,842	4,026,893	11,471,735	-603,306	10,868,429 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,898,570	1,047,587	2,946,157	-283,152	2,663,005 55.00
57.00	05700	CT SCAN	936,357	538,104	1,474,461	225,320	1,699,781 57.00
58.00	05800	MRI	2,331,236	986,920	3,318,156	37,798	3,355,954 58.00
59.00	05900	CARDIAC CATHETERIZATION	1,479,600	4,545,639	6,025,239	-3,505,773	2,519,466 59.00
60.00	06000	LABORATORY	3,979,583	8,539,505	12,519,088	-913,258	11,605,830 60.00
65.00	06500	RESPIRATORY THERAPY	1,665,410	1,151,368	2,816,778	-188,949	2,627,829 65.00
66.00	06600	PHYSICAL THERAPY	2,079,024	559,293	2,638,317	-265,173	2,373,144 66.00
68.00	06800	SPEECH PATHOLOGY	819,964	416,495	1,236,459	-170,429	1,066,030 68.00
69.00	06900	ELECTROCARDIOLOGY	1,063,843	304,912	1,368,755	-193,604	1,175,151 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	245,393	204,735	450,128	99,438	549,566 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,408,650	6,408,650 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9,611,922	9,611,922 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	48,088,884	48,088,884 73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0 74.00
76.97	07697	CARDIAC REHABILITATION	585,222	169,717	754,939	-108,142	646,797 76.97
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OP PEDS ONC CLINIC	1,738,283	878,433	2,616,716	-361,107	2,255,609 90.01
90.02	09002	WOUND CLINIC	648,920	962,334	1,611,254	-118,330	1,492,924 90.02
91.00	09100	EMERGENCY	6,831,181	3,842,700	10,673,881	-1,245,014	9,428,867 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	190	1,617	1,807	-53	1,754 92.01
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	107,211,686	324,250,515	431,462,201	0	431,462,201 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	-11	-11	0	-11 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	352,421	4,579,344	4,931,765	0	4,931,765 192.00
194.00	07950	HEALTH & FITNESS CENTER	143,972	3,568,408	3,712,380	0	3,712,380 194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0 194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	107,708,079	332,398,256	440,106,335	0	440,106,335 200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020

Worksheet A

Date/Time Prepared:
3/26/2021 12:42 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	6,372,162	28,818,307	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-2,772,248	11,453,590	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	309,163	20,547,583	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-20,080,870	136,054,130	5.00
7.00	00700	OPERATION OF PLANT	-47,563	17,615,067	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-18,400	1,094,749	8.00
9.00	00900	HOUSEKEEPING	-154	3,482,554	9.00
10.00	01000	DIETARY	-814,409	1,898,943	10.00
11.00	01100	CAFETERIA	-530,049	2,915,676	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	-4,794	16,064	12.00
13.00	01300	NURSING ADMINISTRATION	-267,718	7,064,944	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-36,901	2,856,535	14.00
15.00	01500	PHARMACY	-8,677	952,247	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	1,838,513	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	-14,840	582,392	22.00
23.00	02300	PARAMED ED PRGM-(EMS)	-30,000	48,138	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-11,210	28,667,836	30.00
31.00	03100	INTENSIVE CARE UNIT	0	6,687,609	31.00
43.00	04300	NURSERY	0	2,752,681	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-26,588	16,258,653	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-22,780	3,410,522	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-139,114	10,729,315	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-16,603	2,646,402	55.00
57.00	05700	CT SCAN	-2,571	1,697,210	57.00
58.00	05800	MRI	-33,880	3,322,074	58.00
59.00	05900	CARDIAC CATHETERIZATION	-17,141	2,502,325	59.00
60.00	06000	LABORATORY	-293,763	11,312,067	60.00
65.00	06500	RESPIRATORY THERAPY	-591	2,627,238	65.00
66.00	06600	PHYSICAL THERAPY	-889	2,372,255	66.00
68.00	06800	SPEECH PATHOLOGY	-994	1,065,036	68.00
69.00	06900	ELECTROCARDIOLOGY	-4,837	1,170,314	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	549,566	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,408,650	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,611,922	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	48,088,884	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	-6,706	640,091	76.97
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OP PEDS ONC CLINIC	-1,046	2,254,563	90.01
90.02	09002	WOUND CLINIC	-1,144	1,491,780	90.02
91.00	09100	EMERGENCY	-14,354	9,414,513	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	-333	1,421	92.01
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-18,539,842	412,922,359	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	-11	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,931,765	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	3,712,380	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-18,539,842	421,566,493	200.00

RECLASSIFICATIONS

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020

Worksheet A-6

Date/Time Prepared:
3/26/2021 12:42 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - MED SUPPLY & IMPLANT RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	6,408,650		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	9,611,922		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
16.00		0.00	0	0		16.00
18.00		0.00	0	0		18.00
20.00		0.00	0	0		20.00
	TOTALS		0	16,020,572		
	C - DRUG RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	48,088,884		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
	TOTALS		0	48,088,884		
	D - ADMINISTRATIVE RADIOLOGY RECLASS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	566,579	180,990		1.00
2.00	CT SCAN	57.00	293,509	93,760		2.00
3.00	MRI	58.00	354,371	113,202		3.00
4.00	PHYSICAL THERAPY	66.00	21,428	6,845		4.00
5.00	ELECTROENCEPHALOGRAPHY	70.00	6,761	2,160		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
	TOTALS		1,242,648	396,957		
	E - RESTRICTED FUNDS RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	160,996		1.00
2.00	OPERATION OF PLANT	7.00	0	34,563		2.00
3.00	NURSING ADMINISTRATION	13.00	381	4,100		3.00
4.00	ADULTS & PEDIATRICS	30.00	111,689	228,630		4.00
5.00	OPERATING ROOM	50.00	6,200	0		5.00
6.00	RADIOLOGY-THERAPEUTIC	55.00	0	7,865		6.00
7.00	CARDIAC CATHETERIZATION	59.00	133,570	45,334		7.00
8.00	LABORATORY	60.00	0	7,137		8.00
9.00	RESPIRATORY THERAPY	65.00	167,793	3,425		9.00
10.00	PHYSICAL THERAPY	66.00	73,544	2,381		10.00
11.00	SPEECH PATHOLOGY	68.00	0	23		11.00
12.00	ELECTROENCEPHALOGRAPHY	70.00	117,908	19,064		12.00
13.00	CARDIAC REHABILITATION	76.97	1,035	640		13.00
14.00	OP PEDS ONC CLINIC	90.01	0	70		14.00
	TOTALS		612,120	514,228		
	H - NURSERY RECLASS					
1.00	NURSERY	43.00	651,451	335,647		1.00
	TOTALS		651,451	335,647		
	J - DIETARY RECLASS					
1.00	CAFETERIA	11.00	0	2,585,183		1.00
	TOTALS		0	2,585,183		
	K - EMPL BENE RCL ACCR TO NON SALARY					
1.00	ADMINISTRATIVE & GENERAL	5.00	841,459	0		1.00
	TOTALS		841,459	0		

RECLASSIFICATIONS

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020

Worksheet A-6

Date/Time Prepared:
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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	L - EMERGENCY INCIDENT					
1.00	ADULTS & PEDIATRICS	30.00	1,648,122	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	31,985	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	8,018	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	350,259	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	102	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	7,015	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	104	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	25,125	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	31,002	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	144,907		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	21,290		11.00
12.00	ADULTS & PEDIATRICS	30.00	0	4,496		12.00
13.00	ADULTS & PEDIATRICS	30.00	0	192,702		13.00
14.00	ADULTS & PEDIATRICS	30.00	0	400,213		14.00
15.00	ADULTS & PEDIATRICS	30.00	0	494,321		15.00
16.00	ADULTS & PEDIATRICS	30.00	0	7,916		16.00
17.00	ADULTS & PEDIATRICS	30.00	0	8,200		17.00
18.00	ADULTS & PEDIATRICS	30.00	0	945,065		18.00
19.00	ADULTS & PEDIATRICS	30.00	0	59		19.00
20.00	ADULTS & PEDIATRICS	30.00	0	532		20.00
21.00	ADULTS & PEDIATRICS	30.00	0	780		21.00
22.00	ADULTS & PEDIATRICS	30.00	0	186		22.00
23.00	ADULTS & PEDIATRICS	30.00	0	4,324		23.00
24.00	ADULTS & PEDIATRICS	30.00	0	34,695		24.00
25.00	ADULTS & PEDIATRICS	30.00	0	1,494		25.00
26.00	ADULTS & PEDIATRICS	30.00	0	225		26.00
27.00	ADULTS & PEDIATRICS	30.00	0	374,449		27.00
28.00	ADULTS & PEDIATRICS	30.00	0	2,563		28.00
29.00	ADULTS & PEDIATRICS	30.00	0	2,423		29.00
30.00	ADULTS & PEDIATRICS	30.00	0	17,967		30.00
31.00	ADULTS & PEDIATRICS	30.00	0	3,054		31.00
32.00	ADMINISTRATIVE & GENERAL	5.00	0	301		32.00
33.00	ADULTS & PEDIATRICS	30.00	0	6,894		33.00
34.00	ADULTS & PEDIATRICS	30.00	0	29,847		34.00
35.00	ADULTS & PEDIATRICS	30.00	0	405		35.00
36.00	ADULTS & PEDIATRICS	30.00	0	3,895		36.00
37.00	ADULTS & PEDIATRICS	30.00	0	105		37.00
38.00	ADULTS & PEDIATRICS	30.00	0	1,647		38.00
39.00	ADULTS & PEDIATRICS	30.00	0	2,767		39.00
40.00	ADULTS & PEDIATRICS	30.00	0	15,425		40.00
41.00	ADMINISTRATIVE & GENERAL	5.00	0	3,516		41.00
42.00	ADULTS & PEDIATRICS	30.00	0	22,989		42.00
43.00	ADULTS & PEDIATRICS	30.00	0	22,865		43.00
44.00	ADULTS & PEDIATRICS	30.00	0	30		44.00
45.00	ADULTS & PEDIATRICS	30.00	0	686		45.00
46.00	ADULTS & PEDIATRICS	30.00	0	719		46.00
47.00	ADULTS & PEDIATRICS	30.00	0	24		47.00
48.00	ADULTS & PEDIATRICS	30.00	0	200		48.00
49.00	ADULTS & PEDIATRICS	30.00	0	374		49.00
50.00	ADULTS & PEDIATRICS	30.00	0	58,360		50.00
51.00	ADULTS & PEDIATRICS	30.00	0	10,656		51.00
52.00	ADULTS & PEDIATRICS	30.00	0	1,932		52.00
53.00	ADULTS & PEDIATRICS	30.00	0	16,989		53.00
54.00	ADULTS & PEDIATRICS	30.00	0	730		54.00
55.00	ADULTS & PEDIATRICS	30.00	0	2,316		55.00
56.00	ADULTS & PEDIATRICS	30.00	0	2,685		56.00
57.00	ADULTS & PEDIATRICS	30.00	0	26,812		57.00
58.00	ADMINISTRATIVE & GENERAL	5.00	0	3,701		58.00
59.00	ADULTS & PEDIATRICS	30.00	0	1,012		59.00
60.00	ADULTS & PEDIATRICS	30.00	0	105,463		60.00
61.00	ADMINISTRATIVE & GENERAL	5.00	0	71		61.00
	TOTALS		2,101,732	3,005,277		
	M - ACCOUNT 648000 RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	19,648,550		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	106,651		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	400,213		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

RECLASSIFICATIONS

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020

Worksheet A-6

Date/Time Prepared:
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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35.00
	TOTALS		0	20,155,414		
	N - EMS PARAMED ED PROGRAM					
1.00	PARAMED ED PRGM-(EMS)	23.00	21,938	56,200		1.00
	TOTALS		21,938	56,200		
500.00	Grand Total: Increases		5,471,348	91,158,362		500.00

RECLASSIFICATIONS

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020

Worksheet A-6

Date/Time Prepared:
3/26/2021 12:42 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - MED SUPPLY & IMPLANT RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	0	8,964	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	2,261	0		2.00
3.00	NURSERY	43.00	0	17	0		3.00
4.00	OPERATING ROOM	50.00	0	4,864,109	0		4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	0	36,609	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	14,078	0		6.00
7.00	CT SCAN	57.00	0	645	0		7.00
8.00	MRI	58.00	0	65	0		8.00
9.00	CARDIAC CATHETERIZATION	59.00	0	1,421,666	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	43,821	0		10.00
11.00	SPEECH PATHOLOGY	68.00	0	23	0		11.00
12.00	ELECTROENCEPHALOGRAPHY	70.00	0	744	0		12.00
13.00	OP PEDS ONC CLINIC	90.01	0	8,879	0		13.00
14.00	EMERGENCY	91.00	0	6,769	0		14.00
16.00	OPERATING ROOM	50.00	0	7,601,698	0		16.00
18.00	CARDIAC CATHETERIZATION	59.00	0	2,010,155	0		18.00
20.00	WOUND CLINIC	90.02	0	69	0		20.00
	TOTALS		0	16,020,572			
	C - DRUG RECLASS						
1.00		0.00	0	0	0		1.00
2.00	PHARMACY	15.00	0	48,087,025	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	170	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	63	0		4.00
5.00	OPERATING ROOM	50.00	0	287	0		5.00
6.00	DELIVERY ROOM & LABOR ROOM	52.00	0	66	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	65	0		7.00
8.00	CT SCAN	57.00	0	309	0		8.00
9.00	MRI	58.00	0	157	0		9.00
10.00	CARDIAC CATHETERIZATION	59.00	0	264	0		10.00
11.00	LABORATORY	60.00	0	97	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	1	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	7	0		13.00
14.00	OP PEDS ONC CLINIC	90.01	0	132	0		14.00
15.00	WOUND CLINIC	90.02	0	146	0		15.00
16.00	EMERGENCY	91.00	0	95	0		16.00
	TOTALS		0	48,088,884			
	D - ADMINISTRATIVE RADIOLOGY RECLASS						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00	ADMINISTRATIVE & GENERAL	5.00	1,242,648	0	0		6.00
7.00	ADMINISTRATIVE & GENERAL	5.00	0	396,957	0		7.00
	TOTALS		1,242,648	396,957			
	E - RESTRICTED FUNDS RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	160,996	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	34,563	0		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	381	4,100	0		3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	111,689	228,630	0		4.00
5.00	ADMINISTRATIVE & GENERAL	5.00	6,200	0	0		5.00
6.00	ADMINISTRATIVE & GENERAL	5.00	0	7,865	0		6.00
7.00	ADMINISTRATIVE & GENERAL	5.00	133,570	45,334	0		7.00
8.00	ADMINISTRATIVE & GENERAL	5.00	0	7,137	0		8.00
9.00	ADMINISTRATIVE & GENERAL	5.00	167,793	3,425	0		9.00
10.00	ADMINISTRATIVE & GENERAL	5.00	73,544	2,381	0		10.00
11.00	ADMINISTRATIVE & GENERAL	5.00	0	23	0		11.00
12.00	ADMINISTRATIVE & GENERAL	5.00	117,908	19,064	0		12.00
13.00	ADMINISTRATIVE & GENERAL	5.00	1,035	640	0		13.00
14.00	ADMINISTRATIVE & GENERAL	5.00	0	70	0		14.00
	TOTALS		612,120	514,228			
	H - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	651,451	335,647	0		1.00
	TOTALS		651,451	335,647			
	J - DIETARY RECLASS						
1.00	DIETARY	10.00	0	2,585,183	0		1.00
	TOTALS		0	2,585,183			
	K - EMPL BENE RCL ACCR TO NON SALARY						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	841,459	0	0		1.00
	TOTALS		841,459	0			

RECLASSIFICATIONS

Provider CCN: 14-0130

Period:
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To 08/31/2020

Worksheet A-6

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	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	L - EMERGENCY INCIDENT						
1.00	ADMINISTRATIVE & GENERAL	5.00	1,648,122	0	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	31,985	0	0		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	8,018	0	0		3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	350,259	0	0		4.00
5.00	ADMINISTRATIVE & GENERAL	5.00	102	0	0		5.00
6.00	ADMINISTRATIVE & GENERAL	5.00	7,015	0	0		6.00
7.00	ADMINISTRATIVE & GENERAL	5.00	104	0	0		7.00
8.00	ADMINISTRATIVE & GENERAL	5.00	25,125	0	0		8.00
9.00	ADMINISTRATIVE & GENERAL	5.00	31,002	0	0		9.00
10.00	ADMINISTRATIVE & GENERAL	5.00	0	144,907	0		10.00
11.00	ADMINISTRATIVE & GENERAL	5.00	0	21,290	0		11.00
12.00	ADMINISTRATIVE & GENERAL	5.00	0	4,496	0		12.00
13.00	ADMINISTRATIVE & GENERAL	5.00	0	192,702	0		13.00
14.00	ADMINISTRATIVE & GENERAL	5.00	0	400,213	0		14.00
15.00	ADMINISTRATIVE & GENERAL	5.00	0	494,321	0		15.00
16.00	ADMINISTRATIVE & GENERAL	5.00	0	7,916	0		16.00
17.00	ADMINISTRATIVE & GENERAL	5.00	0	8,200	0		17.00
18.00	ADMINISTRATIVE & GENERAL	5.00	0	945,065	0		18.00
19.00	ADMINISTRATIVE & GENERAL	5.00	0	59	0		19.00
20.00	ADMINISTRATIVE & GENERAL	5.00	0	532	0		20.00
21.00	ADMINISTRATIVE & GENERAL	5.00	0	780	0		21.00
22.00	ADMINISTRATIVE & GENERAL	5.00	0	186	0		22.00
23.00	ADMINISTRATIVE & GENERAL	5.00	0	4,324	0		23.00
24.00	ADMINISTRATIVE & GENERAL	5.00	0	34,695	0		24.00
25.00	ADMINISTRATIVE & GENERAL	5.00	0	1,494	0		25.00
26.00	ADMINISTRATIVE & GENERAL	5.00	0	225	0		26.00
27.00	ADMINISTRATIVE & GENERAL	5.00	0	374,449	0		27.00
28.00	ADMINISTRATIVE & GENERAL	5.00	0	2,563	0		28.00
29.00	ADMINISTRATIVE & GENERAL	5.00	0	2,423	0		29.00
30.00	ADMINISTRATIVE & GENERAL	5.00	0	17,967	0		30.00
31.00	ADMINISTRATIVE & GENERAL	5.00	0	3,054	0		31.00
32.00	ADULTS & PEDIATRICS	30.00	0	301	0		32.00
33.00	ADMINISTRATIVE & GENERAL	5.00	0	6,894	0		33.00
34.00	ADMINISTRATIVE & GENERAL	5.00	0	29,847	0		34.00
35.00	ADMINISTRATIVE & GENERAL	5.00	0	405	0		35.00
36.00	ADMINISTRATIVE & GENERAL	5.00	0	3,895	0		36.00
37.00	ADMINISTRATIVE & GENERAL	5.00	0	105	0		37.00
38.00	ADMINISTRATIVE & GENERAL	5.00	0	1,647	0		38.00
39.00	ADMINISTRATIVE & GENERAL	5.00	0	2,767	0		39.00
40.00	ADMINISTRATIVE & GENERAL	5.00	0	15,425	0		40.00
41.00	ADULTS & PEDIATRICS	30.00	0	3,516	0		41.00
42.00	ADMINISTRATIVE & GENERAL	5.00	0	22,989	0		42.00
43.00	ADMINISTRATIVE & GENERAL	5.00	0	22,865	0		43.00
44.00	ADMINISTRATIVE & GENERAL	5.00	0	30	0		44.00
45.00	ADMINISTRATIVE & GENERAL	5.00	0	686	0		45.00
46.00	ADMINISTRATIVE & GENERAL	5.00	0	719	0		46.00
47.00	ADMINISTRATIVE & GENERAL	5.00	0	24	0		47.00
48.00	ADMINISTRATIVE & GENERAL	5.00	0	200	0		48.00
49.00	ADMINISTRATIVE & GENERAL	5.00	0	374	0		49.00
50.00	ADMINISTRATIVE & GENERAL	5.00	0	58,360	0		50.00
51.00	ADMINISTRATIVE & GENERAL	5.00	0	10,656	0		51.00
52.00	ADMINISTRATIVE & GENERAL	5.00	0	1,932	0		52.00
53.00	ADMINISTRATIVE & GENERAL	5.00	0	16,989	0		53.00
54.00	ADMINISTRATIVE & GENERAL	5.00	0	730	0		54.00
55.00	ADMINISTRATIVE & GENERAL	5.00	0	2,316	0		55.00
56.00	ADMINISTRATIVE & GENERAL	5.00	0	2,685	0		56.00
57.00	ADMINISTRATIVE & GENERAL	5.00	0	26,812	0		57.00
58.00	ADMINISTRATIVE & GENERAL	5.00	0	3,701	0		58.00
59.00	ADMINISTRATIVE & GENERAL	5.00	0	1,012	0		59.00
60.00	ADMINISTRATIVE & GENERAL	5.00	0	105,463	0		60.00
61.00	ADMINISTRATIVE & GENERAL	5.00	0	71	0		61.00
	TOTALS		2,101,732	3,005,277			
	M - ACCOUNT 648000 RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,121,227	0		1.00
2.00	OPERATION OF PLANT	7.00	0	1,044,171	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	69,425	0		3.00
4.00	HOUSEKEEPING	9.00	0	958,743	0		4.00
5.00	DIETARY	10.00	0	30,274	0		5.00
6.00	MAINTENANCE OF PERSONNEL	12.00	0	170	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	982,969	0		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	405,296	0		8.00
9.00	PHARMACY	15.00	0	462,232	0		9.00

RECLASSIFICATIONS

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020

Worksheet A-6

Date/Time Prepared:
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Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
10.00	I&R SERVICES-OTHER PRGM	22.00	0	29,616	0	10.00
	COSTS APPRV					
11.00	ADULTS & PEDIATRICS	30.00	0	4,081,378	0	11.00
12.00	INTENSIVE CARE UNIT	31.00	0	629,296	0	12.00
13.00	NURSERY	43.00	0	155,816	0	13.00
14.00	OPERATING ROOM	50.00	0	1,912,039	0	14.00
15.00	DELIVERY ROOM & LABOR ROOM	52.00	0	460,957	0	15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,336,732	0	16.00
17.00	RADIOLOGY-THERAPEUTIC	55.00	0	291,017	0	17.00
18.00	CT SCAN	57.00	0	160,995	0	18.00
19.00	MRI	58.00	0	429,553	0	19.00
20.00	CARDIAC CATHETERIZATION	59.00	0	252,592	0	20.00
21.00	LABORATORY	60.00	0	920,298	0	21.00
22.00	RESPIRATORY THERAPY	65.00	0	316,345	0	22.00
23.00	PHYSICAL THERAPY	66.00	0	369,371	0	23.00
24.00	SPEECH PATHOLOGY	68.00	0	170,429	0	24.00
25.00	ELECTROCARDIOLOGY	69.00	0	193,597	0	25.00
26.00	ELECTROENCEPHALOGRAPHY	70.00	0	45,711	0	26.00
27.00	CARDIAC REHABILITATION	76.97	0	109,817	0	27.00
28.00	OP PEDS ONC CLINIC	90.01	0	352,166	0	28.00
29.00	WOUND CLINIC	90.02	0	118,115	0	29.00
30.00	EMERGENCY	91.00	0	1,238,150	0	30.00
31.00	OBSERVATION BEDS (DISTINCT PART)	92.01	0	53	0	31.00
34.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	106,651	0	34.00
35.00	ADULTS & PEDIATRICS	30.00	0	400,213	0	35.00
	TOTALS		0	20,155,414		
N - EMS PARAMED ED PROGRAM						
1.00	ADMINISTRATIVE & GENERAL	5.00	21,938	56,200	0	1.00
	TOTALS		21,938	56,200		
500.00	Grand Total: Decreases		5,471,348	91,158,362		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020Worksheet A-7
Part I
Date/Time Prepared:
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		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	52,023,598	0	0	0	0	1.00	
2.00	Land Improvements	0	0	0	0	0	2.00	
3.00	Buildings and Fixtures	548,513,146	19,186,724	0	19,186,724	33,094,077	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	106,606,550	7,792,379	169,437	7,961,816	618,695	5.00	
6.00	Movable Equipment	0	0	0	0	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	707,143,294	26,979,103	169,437	27,148,540	33,712,772	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	707,143,294	26,979,103	169,437	27,148,540	33,712,772	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	52,023,598	0				1.00	
2.00	Land Improvements	0	0				2.00	
3.00	Buildings and Fixtures	534,605,793	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	113,949,671	0				5.00	
6.00	Movable Equipment	0	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	700,579,062	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	700,579,062	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020Worksheet A-7
Part II
Date/Time Prepared:
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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	22,446,145	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	14,225,838	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	36,671,983	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	22,446,145				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	14,225,838				2.00
3.00	Total (sum of lines 1-2)	0	36,671,983				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020Worksheet A-7
Part III
Date/Time Prepared:
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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	534,605,793	0	534,605,793	0.824302	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	113,949,670	0	113,949,670	0.175698	0	2.00
3.00	Total (sum of lines 1-2)	648,555,463	0	648,555,463	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	28,818,307	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	11,453,590	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	40,271,897	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	28,818,307	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	11,453,590	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	40,271,897	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020

Worksheet A-8

Date/Time Prepared:
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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	0			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	-14,618,308			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
19.02	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.02
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	0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	0PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	0*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	0*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0	0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	0*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020

Worksheet A-8

Date/Time Prepared:
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Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #	Wkst. A-7 Ref.
				Cost Center			
		1.00	2.00	3.00		4.00	5.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00	
32.00	CAH HIT Adjustment for Depreciation and Interest		0			0.00	0 32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.00
33.01	ACCT 410000 NUTRITIONAL SUP_3225	B	215		ADULTS & PEDIATRICS	30.00	0 33.01
33.02	ACCT 410000 NUTRITIONAL SUP_3290	B	186		EMERGENCY	91.00	0 33.02
33.03	ACCT 410000 NUTRITIONAL SUP_3320	B	82		DELIVERY ROOM & LABOR ROOM	52.00	0 33.03
33.04	ACCT 410000 NUTRITIONAL SUP_3321	B	68		ADULTS & PEDIATRICS	30.00	0 33.04
33.05	ACCT 410000 NUTRITIONAL SUP_3550	B	-38		EMERGENCY	91.00	0 33.05
33.06	ACCT 410200 VENDING MACHINE_3160	B	-8,075		DIETARY	10.00	0 33.06
33.07	ACCT 410400 DIETARY GUEST TRAYS_3160	B	-21,971		DIETARY	10.00	0 33.07
33.08	ACCT 411800 OTHER FOOD SERV_3160	B	-779,736		DIETARY	10.00	0 33.08
33.09	ACCT 411800 OTHER FOOD SERV_3165	B	-373,152		CAFETERIA	11.00	0 33.09
33.10	ACCT 411800 OTHER FOOD SERV_3520	B	-155,882		CAFETERIA	11.00	0 33.10
33.12	ACCT 415200 BUILDING RENT_3013	B	759		OPERATION OF PLANT	7.00	0 33.12
33.13	ACCT 415200 BUILDING RENT_3031	B	1,933		ADMINISTRATIVE & GENERAL	5.00	0 33.13
33.19	ACCT 415200 BUILDING RENT_3723	B	-36,594		MAINTENANCE OF PERSONNEL	12.00	0 33.19
33.20	OTHER ADJUSTMENTS (SPECIFY) (3)	B	0			0.00	0 33.20
34.01	OTHER ADJUSTMENTS (SPECIFY) (3)	B	0			0.00	0 34.01
34.06	OTHER ADJUSTMENTS (SPECIFY) (3)	B	0			0.00	0 34.06
34.07	OTHER ADJUSTMENTS (SPECIFY) (3)	B	0			0.00	0 34.07
34.08	ACCT 415225 IC BUILDING RENT_3440	B	-50,844		RADIOLOGY-DIAGNOSTIC	54.00	0 34.08
34.10	OTHER ADJUSTMENTS (SPECIFY) (3)	B	0			0.00	0 34.10
34.12	ACCT 415225 IC BUILDING RENT_3719	B	-350,445		EMPLOYEE BENEFITS DEPARTMENT	4.00	0 34.12
39.02	ACCT 415521 RENT REV CONTR INC_3039	B	5,525		CAP REL COSTS-BLDG & FIXT	1.00	9 39.02
40.01	OTHER ADJUSTMENTS (SPECIFY) (3)	B	0			0.00	0 40.01
43.00	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0			0.00	0 43.00
43.01	EXCLUDED COST	A	-335,848		ADMINISTRATIVE & GENERAL	5.00	0 43.01
43.02	EXCLUDED COST	A	-19,147		OPERATION OF PLANT	7.00	0 43.02
43.03	EXCLUDED COST	A	-154		HOUSEKEEPING	9.00	0 43.03
43.04	EXCLUDED COST	A	-4,627		DIETARY	10.00	0 43.04
43.05	EXCLUDED COST	A	-1,015		CAFETERIA	11.00	0 43.05
43.06	EXCLUDED COST	A	-27,980		NURSING ADMINISTRATION	13.00	0 43.06
43.07	EXCLUDED COST	A	-36,901		CENTRAL SERVICES & SUPPLY	14.00	0 43.07
43.08	EXCLUDED COST	A	-2,361		PHARMACY	15.00	0 43.08
43.09	EXCLUDED COST	A	-14,840		I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0 43.09
43.10	EXCLUDED COST	A	-7,674		ADULTS & PEDIATRICS	30.00	0 43.10
43.11	EXCLUDED COST	A	-1,209		OPERATING ROOM	50.00	0 43.11
43.12	EXCLUDED COST	A	-910		DELIVERY ROOM & LABOR ROOM	52.00	0 43.12
43.13	EXCLUDED COST	A	-4,032		RADIOLOGY-DIAGNOSTIC	54.00	0 43.13
43.14	EXCLUDED COST	A	-16,603		RADIOLOGY-THERAPEUTIC	55.00	0 43.14
43.15	EXCLUDED COST	A	-11,700		CARDIAC CATHETERIZATION	59.00	0 43.15
43.16	EXCLUDED COST	A	-4,961		LABORATORY	60.00	0 43.16
43.17	EXCLUDED COST	A	-163		RESPIRATORY THERAPY	65.00	0 43.17
43.18	EXCLUDED COST	A	-3		PHYSICAL THERAPY	66.00	0 43.18
43.19	EXCLUDED COST	A	-994		SPEECH PATHOLOGY	68.00	0 43.19

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020

Worksheet A-8

Date/Time Prepared:
3/26/2021 12:42 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
43.20	EXCLUDED COST	A	-6,500	ELECTROCARDIOLOGY	69.00	0	43.20
43.21	EXCLUDED COST	A	-4,096	CARDIAC REHABILITATION	76.97	0	43.21
43.22	EXCLUDED COST	A	-1,046	OP PEDS ONC CLINIC	90.01	0	43.22
43.23	EXCLUDED COST	A	-1,144	WOUND CLINIC	90.02	0	43.23
43.24	EXCLUDED COST	A	-5,440	EMERGENCY	91.00	0	43.24
43.25	OTHER ADJUSTMENTS (SPECIFY) (3)	B	0		0.00	0	43.25
43.26	OTHER ADJUSTMENTS (SPECIFY) (3)	B	0		0.00	0	43.26
43.27	OTHER ADJUSTMENTS (SPECIFY) (3)	B	0		0.00	0	43.27
43.28	ACCT 415600 APARTMENT RENT_3723	B	31,800	MAINTENANCE OF PERSONNEL	12.00	0	43.28
43.34	ACCT 430410 IC CORPORATE REV_3036	B	4,344	ADMINISTRATIVE & GENERAL	5.00	0	43.34
43.35	ACCT 430410 IC CORPORATE REV_3347	B	-20,988	RADIOLOGY-DIAGNOSTIC	54.00	0	43.35
43.36	ACCT 430410 IC CORPORATE REV_3350	B	-1,434	RADIOLOGY-DIAGNOSTIC	54.00	0	43.36
43.37	ACCT 430410 IC CORPORATE REV_3413	B	-245,171	LABORATORY	60.00	0	43.37
43.38	ACCT 430410 IC CORPORATE REV_3415	B	-4,994	LABORATORY	60.00	0	43.38
43.39	ACCT 430410 IC CORPORATE REV_3416	B	-326	LABORATORY	60.00	0	43.39
43.40	ACCT 430410 IC CORPORATE REV_3420	B	-10,566	LABORATORY	60.00	0	43.40
43.41	ACCT 430410 IC CORPORATE REV_3467	B	-10	LABORATORY	60.00	0	43.41
43.42	ACCT 430410 IC CORPORATE REV_3561	B	-1,438	MRI	58.00	0	43.42
43.43	ACCT 430410 IC CORPORATE REV_3575	B	-5,278	LABORATORY	60.00	0	43.43
43.44	430800 CORPORATE BILLING REV_3036	B	-22	ADMINISTRATIVE & GENERAL	5.00	0	43.44
43.45	430800 CORPORATE BILLING REV_3220	B	-199	ADULTS & PEDIATRICS	30.00	0	43.45
43.46	430800 CORPORATE BILLING REV_3230	B	-2,440	ADULTS & PEDIATRICS	30.00	0	43.46
43.47	430800 CORPORATE BILLING REV_3270	B	-428	RESPIRATORY THERAPY	65.00	0	43.47
43.48	430800 CORPORATE BILLING REV_3290	B	-1,484	EMERGENCY	91.00	0	43.48
43.49	430800 CORPORATE BILLING REV_3310	B	-19,169	OPERATING ROOM	50.00	0	43.49
43.50	430800 CORPORATE BILLING REV_3311	B	-1,917	OPERATING ROOM	50.00	0	43.50
43.51	430800 CORPORATE BILLING REV_3312	B	-2,664	OPERATING ROOM	50.00	0	43.51
43.52	430800 CORPORATE BILLING REV_3347	B	653	RADIOLOGY-DIAGNOSTIC	54.00	0	43.52
43.53	430800 CORPORATE BILLING REV_3390	B	-529	PHARMACY	15.00	0	43.53
43.54	430800 CORPORATE BILLING REV_3411	B	-373	LABORATORY	60.00	0	43.54
43.55	430800 CORPORATE BILLING REV_3413	B	-110	LABORATORY	60.00	0	43.55
43.56	430800 CORPORATE BILLING REV_3414	B	-222	LABORATORY	60.00	0	43.56
43.57	430800 CORPORATE BILLING REV_3415	B	-3,006	LABORATORY	60.00	0	43.57
43.58	430800 CORPORATE BILLING REV_3416	B	-4,068	LABORATORY	60.00	0	43.58
43.59	430800 CORPORATE BILLING REV_3418	B	-161	LABORATORY	60.00	0	43.59
43.60	430800 CORPORATE BILLING REV_3419	B	-130	LABORATORY	60.00	0	43.60
43.61	430800 CORPORATE BILLING REV_3420	B	-218	LABORATORY	60.00	0	43.61
43.62	430800 CORPORATE BILLING REV_3443	B	-58,987	RADIOLOGY-DIAGNOSTIC	54.00	0	43.62

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020

Worksheet A-8

Date/Time Prepared:
3/26/2021 12:42 am

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
43.63	430800 CORPORATE BILLING REV_3547	B	-333	OBSERVATION BEDS (DISTINCT PART)	92.01	0 43.63
43.64	430800 CORPORATE BILLING REV_3550	B	-7,578	EMERGENCY	91.00	0 43.64
43.65	430800 CORPORATE BILLING REV_3561	B	-32,442	MRI	58.00	0 43.65
43.66	430800 CORPORATE BILLING REV_3562	B	-1,210	RADIOLOGY-DIAGNOSTIC	54.00	0 43.66
43.67	430800 CORPORATE BILLING REV_3565	B	6,201	ELECTROCARDIOLOGY	69.00	0 43.67
43.68	430800 CORPORATE BILLING REV_3575	B	-10,550	LABORATORY	60.00	0 43.68
43.69	430850 RESEARCH REVENUE_3036	B	-50	ADMINISTRATIVE & GENERAL	5.00	0 43.69
43.70	430850 RESEARCH REVENUE_3280	B	-3,561	ELECTROCARDIOLOGY	69.00	0 43.70
43.71	430850 RESEARCH REVENUE_3285	B	-5,441	CARDIAC CATHETERIZATION	59.00	0 43.71
43.72	430850 RESEARCH REVENUE_3314	B	-1,629	OPERATING ROOM	50.00	0 43.72
43.73	430850 RESEARCH REVENUE_3345	B	-2,571	CT SCAN	57.00	0 43.73
43.74	430850 RESEARCH REVENUE_3390	B	-5,787	PHARMACY	15.00	0 43.74
43.75	430850 RESEARCH REVENUE_3413	B	-296	LABORATORY	60.00	0 43.75
43.76	430850 RESEARCH REVENUE_3415	B	-2,422	LABORATORY	60.00	0 43.76
43.77	430850 RESEARCH REVENUE_3416	B	-244	LABORATORY	60.00	0 43.77
43.78	430850 RESEARCH REVENUE_3420	B	-5	LABORATORY	60.00	0 43.78
43.79	430850 RESEARCH REVENUE_3440	B	-2,272	RADIOLOGY-DIAGNOSTIC	54.00	0 43.79
43.80	430850 RESEARCH REVENUE_3467	B	-33	LABORATORY	60.00	0 43.80
43.81	430850 RESEARCH REVENUE_3564	B	-977	ELECTROCARDIOLOGY	69.00	0 43.81
43.82	430850 RESEARCH REVENUE_3575	B	-619	LABORATORY	60.00	0 43.82
43.83	ACCT 431000 CORP BILL ADJUST_3036	B	34,693	ADMINISTRATIVE & GENERAL	5.00	0 43.83
43.84	ACCT 432500 IC SHARED SERV _3031	B	-157,995	ADMINISTRATIVE & GENERAL	5.00	0 43.84
43.85	ACCT 432500 IC SHARED SERV_3125	B	-18,400	LAUNDRY & LINEN SERVICE	8.00	0 43.85
43.86	ACCT 434010 CONT SERV REV	B	1,570	ADMINISTRATIVE & GENERAL	5.00	0 43.86
43.87	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0 43.87
43.88	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0 43.88
43.89	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0 43.89
43.90	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0 43.90
43.91	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0 43.91
43.92	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0 43.92
43.93	ACCT 434401 IC LEASE EMP REV	A	-239,133	NURSING ADMINISTRATION	13.00	0 43.93
43.94	ACCT 438200 OTH OPER INC_3010	A	-6	ADMINISTRATIVE & GENERAL	5.00	0 43.94
43.95	ACCT 438200 OTH OPER INC_3016	A	-53,374	ADMINISTRATIVE & GENERAL	5.00	0 43.95
43.96	ACCT 438200 OTH OPER INC_3035	A	180	ADMINISTRATIVE & GENERAL	5.00	0 43.96
43.97	ACCT 438200 OTH OPER INC_3135	A	-29,175	OPERATION OF PLANT	7.00	0 43.97
43.98	ACCT 438200 OTH OPER INC_3150	A	-2,898,276	ADMINISTRATIVE & GENERAL	5.00	0 43.98
43.99	ACCT 438200 OTH OPER INC_3215	A	-605	NURSING ADMINISTRATION	13.00	0 43.99
44.00	ACCT 438200 OTH OPER INC_3275	A	-2,610	CARDIAC REHABILITATION	76.97	0 44.00
44.01	ACCT 438200 OTH OPER INC_3292	A	-4,320	ADMINISTRATIVE & GENERAL	5.00	0 44.01
44.02	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0 44.02
44.03	ACCT 438200 OTH OPER INC_3321	A	-1,180	ADULTS & PEDIATRICS	30.00	0 44.03
44.04	ACCT 438200 OTH OPER INC_3324	A	-160	DELIVERY ROOM & LABOR ROOM	52.00	0 44.04
44.05	ACCT 438200 OTH OPER INC_3341	A	-6,304	ADMINISTRATIVE & GENERAL	5.00	0 44.05
44.06	ACCT 438200 OTH OPER INC_3374	A	-484	PHYSICAL THERAPY	66.00	0 44.06
44.07	ACCT 438200 OTH OPER INC_3376	A	-6	PHYSICAL THERAPY	66.00	0 44.07
44.08	ACCT 438200 OTH OPER INC_3460	A	-351	PHYSICAL THERAPY	66.00	0 44.08
44.09	ACCT 438200 OTH OPER INC_3570	A	-45	PHYSICAL THERAPY	66.00	0 44.09
44.10	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0 44.10
44.11	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0 44.11
44.12	ACCT 469999 PAYOR INTER INC_3036	A	-124,408	ADMINISTRATIVE & GENERAL	5.00	0 44.12

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020

Worksheet A-8

Date/Time Prepared:
3/26/2021 12:42 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
44.13	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0	44.13
44.14	ACCT 400200 FEES REGISTR_3324	A	-21,792	DELIVERY ROOM & LABOR ROOM	52.00	0	44.14
44.15	OTHER ADJUSTMENTS (SPECIFY) (3)	B	0		0.00	0	44.15
44.16	ACCT 615201 IC MD LEADERSHIP 7319	B	-32,194	ADMINISTRATIVE & GENERAL	5.00	0	44.16
44.17	ACCT 615201 IC MD LEADERSHIP 7344	B	-24,130	ADMINISTRATIVE & GENERAL	5.00	0	44.17
44.18	ACCT 615201 IC MD LEADERSHIP 7351	B	-25,000	ADMINISTRATIVE & GENERAL	5.00	0	44.18
44.19	ACCT 615201 IC MD LEADERSHIP 7395	B	-50,000	ADMINISTRATIVE & GENERAL	5.00	0	44.19
44.20	ACCT 615200 PROFESSION SVC_7351	B	-20,000	ADMINISTRATIVE & GENERAL	5.00	0	44.20
44.21	ACCT 615600 PROFESSION FEE_7313	B	-583	ADMINISTRATIVE & GENERAL	5.00	0	44.21
44.22	ACCT 744000 CONTRACT PRO_7321	B	-900	ADMINISTRATIVE & GENERAL	5.00	0	44.22
44.23	ACCT 744000 CONTRACT PRO_7313	B	-9,600	ADMINISTRATIVE & GENERAL	5.00	0	44.23
44.24	ACCT 615201 IC MD LEADERSHIP_3016	B	-195,000	ADMINISTRATIVE & GENERAL	5.00	0	44.24
44.25	ACCT 615201 IC MD LEADERSHIP_3016	B	-39,936	ADMINISTRATIVE & GENERAL	5.00	0	44.25
44.26	ACCT 615201 IC MD LEADERSHIP_3016	B	-177,728	ADMINISTRATIVE & GENERAL	5.00	0	44.26
44.27	ACCT 615201 IC MD LEADERSHIP_3016	B	-690,000	ADMINISTRATIVE & GENERAL	5.00	0	44.27
44.28	EXCLUDE LOSS ON DISPOSAL	A	-4,577	CAP REL COSTS-BLDG & FIXT	1.00	9	44.28
44.29	EXCLUDE GAIN ON DISPOSAL	A	14,394	CAP REL COSTS-MVBLE EQUIP	2.00	9	44.29
44.30	ADJUST TO MEDICARE DEPRECIATION	A	6,371,214	CAP REL COSTS-BLDG & FIXT	1.00	9	44.30
44.31	ADJUST TO MEDICARE DEPRECIATION	A	-2,786,642	CAP REL COSTS-MVBLE EQUIP	2.00	9	44.31
44.32	TUITION	B	-30,000	PARAMED ED PRGM-(EMS)	23.00	0	44.32
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-18,539,842				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: 14-0130

Period:
From 09/01/2019
To 08/31/2020

Worksheet A-8-1

Date/Time Prepared:
3/26/2021 12:42 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	0.00			0	0	1.00
2.00	0.00			0	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	MANAGEMENT CHARGE	20,619,814	19,960,206	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT CHARGE	68,236,653	83,514,569	3.01
3.02	0.00			0	0	3.02
3.03	0.00			0	0	3.03
3.04	0.00			0	0	3.04
3.05	0.00			0	0	3.05
3.06	0.00			0	0	3.06
3.07	0.00			0	0	3.07
3.08	0.00			0	0	3.08
3.09	0.00			0	0	3.09
3.10	0.00			0	0	3.10
3.11	0.00			0	0	3.11
3.12	0.00			0	0	3.12
3.13	0.00			0	0	3.13
3.14	0.00			0	0	3.14
3.15	0.00			0	0	3.15
3.16	0.00			0	0	3.16
3.17	0.00			0	0	3.17
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			88,856,467	103,474,775	5.00

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

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

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

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

6.00	B	0.00	NM HEALTHCARE	100.00	6.00
7.00	B	0.00	NM HOSPITAL	100.00	7.00
8.00	B	0.00	NM FOUNDATION	100.00	8.00
9.00	B	0.00	NM MEDICAL GROUP	100.00	9.00
9.01	B	0.00	LF HEALTH AND FITNESS INSTITUTE	100.00	9.01
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: 14-0130

Period:
From 09/01/2019
To 08/31/2020

Worksheet A-8-1

Date/Time Prepared:
3/26/2021 12:42 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	0	0		1.00
2.00	0	0		2.00
3.00	659,608	0		3.00
3.01	-15,277,916	0		3.01
3.02	0	0		3.02
3.03	0	0		3.03
3.04	0	0		3.04
3.05	0	0		3.05
3.06	0	0		3.06
3.07	0	0		3.07
3.08	0	0		3.08
3.09	0	0		3.09
3.10	0	0		3.10
3.11	0	0		3.11
3.12	0	0		3.12
3.13	0	0		3.13
3.14	0	0		3.14
3.15	0	0		3.15
3.16	0	0		3.16
3.17	0	0		3.17
4.00	0	0		4.00
5.00	-14,618,308	0		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	HEALTHCARE		6.00
7.00	HEALTHCARE		7.00
8.00	HEALTHCARE		8.00
9.00	HEALTHCARE		9.00
9.01	HEALTHCARE		9.01
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.

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020Worksheet B
Part I
Date/Time Prepared:
3/26/2021 12:42 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	28,818,307	28,818,307				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	11,453,590		11,453,590			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	20,547,583	6,708	315	20,554,606		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	136,054,130	1,500,748	2,126,192	2,556,477	142,237,547	5.00
7.00	00700	OPERATION OF PLANT	17,615,067	12,958,584	282,669	774,809	31,631,129	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,094,749	34,963	0	32,921	1,162,633	8.00
9.00	00900	HOUSEKEEPING	3,482,554	73,010	29,933	467,382	4,052,879	9.00
10.00	01000	DIETARY	1,898,943	318,151	25,046	25,492	2,267,632	10.00
11.00	01100	CAFETERIA	2,915,676	0	3,143	0	2,918,819	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	16,064	0	0	93	16,157	12.00
13.00	01300	NURSING ADMINISTRATION	7,064,944	59,193	4,059	1,227,226	8,355,422	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,856,535	121,023	132,871	272,207	3,382,636	14.00
15.00	01500	PHARMACY	952,247	115,686	157,520	579,914	1,805,367	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,838,513	0	4,246	290,764	2,133,523	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	582,392	0	0	17,254	599,646	22.00
23.00	02300	PARAMED ED PRGM-(EMS)	48,138	0	0	4,190	52,328	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	28,667,836	2,710,688	291,147	4,075,169	35,744,840	30.00
31.00	03100	INTENSIVE CARE UNIT	6,687,609	329,720	188,219	707,055	7,912,603	31.00
43.00	04300	NURSERY	2,752,681	116,390	9,751	299,781	3,178,603	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	16,258,653	1,856,177	2,396,099	1,881,622	22,392,551	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,410,522	401,649	133,022	470,119	4,415,312	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,729,315	724,795	2,020,746	1,530,149	15,005,005	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,646,402	356,597	390,260	362,619	3,755,878	55.00
57.00	05700	CT SCAN	1,697,210	123,808	905,089	234,899	2,961,006	57.00
58.00	05800	MRI	3,322,074	151,804	694,900	512,940	4,681,718	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,502,325	228,503	834,291	308,109	3,873,228	59.00
60.00	06000	LABORATORY	11,312,067	188,475	272,790	760,084	12,533,416	60.00
65.00	06500	RESPIRATORY THERAPY	2,627,238	83,710	52,027	350,134	3,113,109	65.00
66.00	06600	PHYSICAL THERAPY	2,372,255	97,092	19,254	415,225	2,903,826	66.00
68.00	06800	SPEECH PATHOLOGY	1,065,036	50,904	24,338	156,610	1,296,888	68.00
69.00	06900	ELECTROCARDIOLOGY	1,170,314	138,193	68,316	203,190	1,580,013	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	549,566	75,590	22,273	70,680	718,109	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,408,650	0	0	0	6,408,650	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,611,922	0	0	0	9,611,922	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	48,088,884	0	0	0	48,088,884	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	640,091	313,563	25,382	111,973	1,091,009	76.97
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	2,254,563	705,329	8,007	332,005	3,299,904	90.01
90.02	09002	WOUND CLINIC	1,491,780	163,304	5,251	123,941	1,784,276	90.02
91.00	09100	EMERGENCY	9,414,513	674,730	146,740	1,304,728	11,540,711	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1,421	181,433	3,571	36	186,461	92.01
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	412,922,359	24,860,520	11,277,467	20,459,797	408,693,640	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-11	0	0	0	-11	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,931,765	3,957,787	176,123	67,311	9,132,986	192.00
194.00	07950	HEALTH & FITNESS CENTER	3,712,380	0	0	27,498	3,739,878	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
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)	421,566,493	28,818,307	11,453,590	20,554,606	421,566,493	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020Worksheet B
Part I
Date/Time Prepared:
3/26/2021 12:42 am

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	142,237,547					5.00
7.00	00700	OPERATION OF PLANT	16,651,385	48,282,514				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	612,038	0	1,774,671			8.00
9.00	00900	HOUSEKEEPING	2,133,533	375,337	936,000	7,497,749		9.00
10.00	01000	DIETARY	1,193,736	1,399,051	0	118,138	4,978,557	10.00
11.00	01100	CAFETERIA	1,536,536	0	0	31,504	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	8,505	0	0	15,751	0	12.00
13.00	01300	NURSING ADMINISTRATION	4,398,495	269,113	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,780,701	626,871	0	78,757	0	14.00
15.00	01500	PHARMACY	950,389	591,712	0	47,255	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	173,267	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,123,138	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	315,668	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(EMS)	27,547	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,816,942	12,329,270	511,926	4,426,192	3,654,049	30.00
31.00	03100	INTENSIVE CARE UNIT	4,165,384	1,531,083	56,673	354,411	418,138	31.00
43.00	04300	NURSERY	1,673,293	540,470	129,913	110,261	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,787,976	8,401,228	31,981	819,081	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,324,326	1,865,090	38,604	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,898,995	4,965,594	0	189,018	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,977,184	1,631,510	0	0	0	55.00
57.00	05700	CT SCAN	1,558,745	516,159	0	0	0	57.00
58.00	05800	MRI	2,464,569	674,559	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,038,960	1,005,948	0	0	0	59.00
60.00	06000	LABORATORY	6,597,891	925,158	0	236,273	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,638,815	180,281	0	70,883	0	65.00
66.00	06600	PHYSICAL THERAPY	1,528,644	0	7,934	86,634	0	66.00
68.00	06800	SPEECH PATHOLOGY	682,713	726,175	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	831,757	773,864	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	378,030	343,358	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,373,667	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,059,946	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,315,044	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	574,333	2,600,242	3,854	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	1,737,149	1,100,951	0	370,162	0	90.01
90.02	09002	WOUND CLINIC	939,286	764,700	57,786	0	0	90.02
91.00	09100	EMERGENCY	6,075,307	3,302,292	0	307,156	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	98,158	842,498	0	0	906,370	92.01
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	140,268,785	48,282,514	1,774,671	7,434,743	4,978,557	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	63,006	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HEALTH & FITNESS CENTER	1,968,762	0	0	0	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
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)	142,237,547	48,282,514	1,774,671	7,497,749	4,978,557	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020Worksheet B
Part I
Date/Time Prepared:
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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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	4,486,859					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	50	40,463				12.00
13.00	01300	NURSING ADMINISTRATION	280,532	0	13,303,562			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	117,594	0	0	5,986,559		14.00
15.00	01500	PHARMACY	132,749	0	0	0	3,527,472	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	8,607	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(EMS)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,171,570	0	5,234,857	119,117	42,731	30.00
31.00	03100	INTENSIVE CARE UNIT	178,691	0	1,137,539	11,353	2,107	31.00
43.00	04300	NURSERY	44,933	0	359,718	17	3	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	540,326	0	2,378,451	1,057,496	8,931	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	134,113	0	739,206	21,489	1,232	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	388,322	0	140,237	133,313	761	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	84,286	0	180,900	0	0	55.00
57.00	05700	CT SCAN	46,807	0	15,492	27,645	385	57.00
58.00	05800	MRI	124,590	0	14,138	37,886	230	58.00
59.00	05900	CARDIAC CATHETERIZATION	77,845	0	245,097	539,257	2,117	59.00
60.00	06000	LABORATORY	267,244	10,116	0	555,151	915	60.00
65.00	06500	RESPIRATORY THERAPY	99,557	0	6,639	33,645	25	65.00
66.00	06600	PHYSICAL THERAPY	107,561	10,116	0	119	0	66.00
68.00	06800	SPEECH PATHOLOGY	48,273	0	0	412	0	68.00
69.00	06900	ELECTROCARDIOLOGY	54,669	0	83	469	303	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	15,941	0	0	616	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,635,300	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,773,116	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,464,442	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	31,891	0	123,226	233	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	102,416	0	582,965	2,330	1,242	90.01
90.02	09002	WOUND CLINIC	33,669	0	159,858	5,188	348	90.02
91.00	09100	EMERGENCY	363,844	20,231	1,837,057	30,004	1,700	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	17	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,456,097	40,463	13,155,463	5,984,156	3,527,472	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	23,589	0	39,523	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,173	0	0	0	0	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	108,576	2,403	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
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)	4,486,859	40,463	13,303,562	5,986,559	3,527,472	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020Worksheet B
Part I
Date/Time Prepared:
3/26/2021 12:42 am

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED ED PRGM- (EMS)	
					SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV		
			16.00	17.00	21.00	22.00	23.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	173,267					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	3,256,661			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		923,921		22.00
23.00	02300	PARAMED ED PRGM- (EMS)	0	0			79,875	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,464	0	109,140	923,921	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,358	0	70,556	0	0	31.00
43.00	04300	NURSERY	771	0	3,655	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	23,614	0	898,212	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,785	0	49,865	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,673	0	757,503	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,579	0	146,294	0	0	55.00
57.00	05700	CT SCAN	7,295	0	339,285	0	0	57.00
58.00	05800	MRI	8,955	0	260,492	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,194	0	312,745	0	0	59.00
60.00	06000	LABORATORY	18,633	0	102,259	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,663	0	19,503	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,172	0	7,218	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	359	0	9,124	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,295	0	25,609	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	248	0	8,349	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,838	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,848	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,868	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	120	0	9,515	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	2,309	0	3,001	0	0	90.01
90.02	09002	WOUND CLINIC	1,176	0	1,968	0	0	90.02
91.00	09100	EMERGENCY	15,910	0	55,007	0	79,875	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	140	0	1,339	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	173,267	0	3,190,639	923,921	79,875	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	66,022	0	0	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
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)	173,267	0	3,256,661	923,921	79,875	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020Worksheet B
Part I
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
23.00	02300	PARAMED ED PRGM-(EMS)				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	83,098,019	-1,033,061	82,064,958	30.00
31.00	03100	INTENSIVE CARE UNIT	15,840,896	-70,556	15,770,340	31.00
43.00	04300	NURSERY	6,041,637	-3,655	6,037,982	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	48,339,847	-898,212	47,441,635	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,592,022	-49,865	9,542,157	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,493,421	-757,503	28,735,918	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	7,780,631	-146,294	7,634,337	55.00
57.00	05700	CT SCAN	5,472,819	-339,285	5,133,534	57.00
58.00	05800	MRI	8,267,137	-260,492	8,006,645	58.00
59.00	05900	CARDIAC CATHETERIZATION	8,099,391	-312,745	7,786,646	59.00
60.00	06000	LABORATORY	21,247,056	-102,259	21,144,797	60.00
65.00	06500	RESPIRATORY THERAPY	5,165,120	-19,503	5,145,617	65.00
66.00	06600	PHYSICAL THERAPY	4,653,224	-7,218	4,646,006	66.00
68.00	06800	SPEECH PATHOLOGY	2,763,944	-9,124	2,754,820	68.00
69.00	06900	ELECTROCARDIOLOGY	3,271,062	-25,609	3,245,453	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,464,651	-8,349	1,456,302	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,425,455	0	11,425,455	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,450,832	0	16,450,832	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	76,898,238	0	76,898,238	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	4,434,423	-9,515	4,424,908	76.97
OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	7,202,429	-3,001	7,199,428	90.01
90.02	09002	WOUND CLINIC	3,748,255	-1,968	3,746,287	90.02
91.00	09100	EMERGENCY	23,629,094	-55,007	23,574,087	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	2,034,983	-1,339	2,033,644	92.01
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	406,414,586	-4,114,560	402,300,026	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	126,107	0	126,107	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,206,181	-66,022	9,140,159	192.00
194.00	07950	HEALTH & FITNESS CENTER	5,819,619	0	5,819,619	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	194.01
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	421,566,493	-4,180,582	417,385,911	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0130

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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,708	315	7,023	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,297,226	1,500,748	2,126,192	14,924,166	5.00
7.00	00700	OPERATION OF PLANT	28,934	12,958,584	282,669	13,270,187	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	34,963	0	34,963	8.00
9.00	00900	HOUSEKEEPING	0	73,010	29,933	102,943	9.00
10.00	01000	DIETARY	0	318,151	25,046	343,197	10.00
11.00	01100	CAFETERIA	0	0	3,143	3,143	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	59,193	4,059	63,252	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	105,648	121,023	132,871	359,542	14.00
15.00	01500	PHARMACY	19,195	115,686	157,520	292,401	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	4,246	4,246	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(EMS)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	2,710,688	291,147	3,001,835	30.00
31.00	03100	INTENSIVE CARE UNIT	0	329,720	188,219	517,939	31.00
43.00	04300	NURSERY	0	116,390	9,751	126,141	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,900	1,856,177	2,396,099	4,256,176	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	401,649	133,022	534,671	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,053	724,795	2,020,746	2,755,594	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	356,597	390,260	746,857	55.00
57.00	05700	CT SCAN	0	123,808	905,089	1,028,897	57.00
58.00	05800	MRI	0	151,804	694,900	846,704	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	228,503	834,291	1,062,794	59.00
60.00	06000	LABORATORY	0	188,475	272,790	461,265	60.00
65.00	06500	RESPIRATORY THERAPY	0	83,710	52,027	135,737	65.00
66.00	06600	PHYSICAL THERAPY	0	97,092	19,254	116,346	66.00
68.00	06800	SPEECH PATHOLOGY	0	50,904	24,338	75,242	68.00
69.00	06900	ELECTROCARDIOLOGY	0	138,193	68,316	206,509	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	75,590	22,273	97,863	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	313,563	25,382	338,945	76.97
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OP PEDS ONC CLINIC	9,900	705,329	8,007	723,236	90.01
90.02	09002	WOUND CLINIC	0	163,304	5,251	168,555	90.02
91.00	09100	EMERGENCY	0	674,730	146,740	821,470	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	181,433	3,571	185,004	92.01
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,474,856	24,860,520	11,277,467	47,612,843	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,957,787	176,123	4,133,910	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	0	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	11,474,856	28,818,307	11,453,590	51,746,753	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020Worksheet B
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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,925,036					5.00
7.00	00700	OPERATION OF PLANT	1,747,240	15,017,691				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	64,222	0	99,196			8.00
9.00	00900	HOUSEKEEPING	223,873	116,744	52,318	496,037		9.00
10.00	01000	DIETARY	125,259	435,158	0	7,816	911,439	10.00
11.00	01100	CAFETERIA	161,230	0	0	2,084	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	892	0	0	1,042	0	12.00
13.00	01300	NURSING ADMINISTRATION	461,537	83,704	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	186,850	194,981	0	5,210	0	14.00
15.00	01500	PHARMACY	99,725	184,045	0	3,126	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	11,463	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	117,852	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	33,123	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(EMS)	2,890	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,974,473	3,834,868	28,614	292,830	668,957	30.00
31.00	03100	INTENSIVE CARE UNIT	437,076	476,225	3,168	23,447	76,550	31.00
43.00	04300	NURSERY	175,580	168,107	7,262	7,295	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,236,920	2,613,100	1,788	54,189	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	243,893	580,114	2,158	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	828,846	1,544,488	0	12,505	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	207,467	507,461	0	0	0	55.00
57.00	05700	CT SCAN	163,560	160,545	0	0	0	57.00
58.00	05800	MRI	258,609	209,814	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	213,949	312,888	0	0	0	59.00
60.00	06000	LABORATORY	692,321	287,759	0	15,631	0	60.00
65.00	06500	RESPIRATORY THERAPY	171,962	56,074	0	4,689	0	65.00
66.00	06600	PHYSICAL THERAPY	160,402	0	443	5,732	0	66.00
68.00	06800	SPEECH PATHOLOGY	71,637	225,868	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	87,277	240,701	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	39,667	106,797	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	354,001	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	530,943	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,656,286	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	60,265	808,774	215	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	182,280	342,438	0	24,489	0	90.01
90.02	09002	WOUND CLINIC	98,560	237,851	3,230	0	0	90.02
91.00	09100	EMERGENCY	637,486	1,027,138	0	20,321	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	10,300	262,049	0	0	165,932	92.01
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,718,453	15,017,691	99,196	491,869	911,439	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	4,168	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HEALTH & FITNESS CENTER	206,583	0	0	0	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
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)	14,925,036	15,017,691	99,196	496,037	911,439	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020Worksheet B
Part II
Date/Time Prepared:
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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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	166,457					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	2	1,936				12.00
13.00	01300	NURSING ADMINISTRATION	10,407	0	619,318			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,363	0	0	751,039		14.00
15.00	01500	PHARMACY	4,925	0	0	0	584,419	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	319	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(EMS)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	43,467	0	243,697	14,944	7,080	30.00
31.00	03100	INTENSIVE CARE UNIT	6,629	0	52,956	1,424	349	31.00
43.00	04300	NURSERY	1,667	0	16,746	2	1	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	20,045	0	110,723	132,666	1,480	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,975	0	34,412	2,696	204	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,406	0	6,528	16,724	126	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,127	0	8,421	0	0	55.00
57.00	05700	CT SCAN	1,736	0	721	3,468	64	57.00
58.00	05800	MRI	4,622	0	658	4,753	38	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,888	0	11,410	67,651	351	59.00
60.00	06000	LABORATORY	9,914	484	0	69,645	152	60.00
65.00	06500	RESPIRATORY THERAPY	3,693	0	309	4,221	4	65.00
66.00	06600	PHYSICAL THERAPY	3,990	484	0	15	0	66.00
68.00	06800	SPEECH PATHOLOGY	1,791	0	0	52	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,028	0	4	59	50	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	591	0	0	77	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	205,153	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	222,452	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	573,974	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	1,183	0	5,737	29	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	3,800	0	27,139	292	206	90.01
90.02	09002	WOUND CLINIC	1,249	0	7,442	651	58	90.02
91.00	09100	EMERGENCY	13,498	968	85,520	3,764	282	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	165,316	1,936	612,423	750,738	584,419	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	875	0	1,840	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	266	0	0	0	0	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	5,055	301	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
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)	166,457	1,936	619,318	751,039	584,419	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020Worksheet B
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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED ED PRGM- (EMS)	
					SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV		
			16.00	17.00	21.00	22.00	23.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	11,463					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	122,197			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		33,448		22.00
23.00	02300	PARAMED ED PRGM- (EMS)	0	0			2,891	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	898	0				30.00
31.00	03100	INTENSIVE CARE UNIT	157	0				31.00
43.00	04300	NURSERY	51	0				43.00
44.00	04400	SKILLED NURSING FACILITY	0	0				44.00
45.00	04500	NURSING FACILITY	0	0				45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,574	0				50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	186	0				52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	978	0				54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	305	0				55.00
57.00	05700	CT SCAN	486	0				57.00
58.00	05800	MRI	597	0				58.00
59.00	05900	CARDIAC CATHETERIZATION	280	0				59.00
60.00	06000	LABORATORY	1,242	0				60.00
65.00	06500	RESPIRATORY THERAPY	178	0				65.00
66.00	06600	PHYSICAL THERAPY	78	0				66.00
68.00	06800	SPEECH PATHOLOGY	24	0				68.00
69.00	06900	ELECTROCARDIOLOGY	286	0				69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	17	0				70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	523	0				71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	390	0				72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,903	0				73.00
74.00	07400	RENAL DIALYSIS	0	0				74.00
76.97	07697	CARDIAC REHABILITATION	8	0				76.97
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	154	0				90.01
90.02	09002	WOUND CLINIC	78	0				90.02
91.00	09100	EMERGENCY	1,061	0				91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	9	0				92.01
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0				101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,463	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0				192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0				194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0				194.01
200.00		Cross Foot Adjustments			122,197	33,448	2,891	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	11,463	0	122,197	33,448	2,891	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020Worksheet B
Part II
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
23.00	02300	PARAMED ED PRGM-(EMS)				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,113,078	0	10,113,078	30.00
31.00	03100	INTENSIVE CARE UNIT	1,596,161	0	1,596,161	31.00
43.00	04300	NURSERY	502,954	0	502,954	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,429,301	0	8,429,301	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,403,469	0	1,403,469	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,180,716	0	5,180,716	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,473,761	0	1,473,761	55.00
57.00	05700	CT SCAN	1,359,557	0	1,359,557	57.00
58.00	05800	MRI	1,325,970	0	1,325,970	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,672,316	0	1,672,316	59.00
60.00	06000	LABORATORY	1,538,672	0	1,538,672	60.00
65.00	06500	RESPIRATORY THERAPY	376,986	0	376,986	65.00
66.00	06600	PHYSICAL THERAPY	287,631	0	287,631	66.00
68.00	06800	SPEECH PATHOLOGY	374,667	0	374,667	68.00
69.00	06900	ELECTROCARDIOLOGY	536,983	0	536,983	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	245,036	0	245,036	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	559,677	0	559,677	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	753,785	0	753,785	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,232,163	0	3,232,163	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	1,215,194	0	1,215,194	76.97
OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	1,304,147	0	1,304,147	90.01
90.02	09002	WOUND CLINIC	517,716	0	517,716	90.02
91.00	09100	EMERGENCY	2,611,952	0	2,611,952	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	623,295	0	623,295	92.01
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	47,235,187	0	47,235,187	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,883	0	6,883	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,134,199	0	4,134,199	192.00
194.00	07950	HEALTH & FITNESS CENTER	211,948	0	211,948	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	194.01
200.00		Cross Foot Adjustments	158,536	0	158,536	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	51,746,753	0	51,746,753	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020

Worksheet B-1

Date/Time Prepared:
3/26/2021 12:42 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			BLDG & FIXT (DV SQUARE FEET)	MVBLE EQUIP (ASSIGNED TIME)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	28,812,781					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		12,485,392				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,707	343	107,618,025			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,500,460	2,317,732	13,384,975	-142,237,547	270,195,971	5.00
7.00	00700	OPERATION OF PLANT	12,956,101	308,134	4,056,678	0	31,631,129	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	34,956	0	172,364	0	1,162,633	8.00
9.00	00900	HOUSEKEEPING	72,996	32,630	2,447,078	0	4,052,879	9.00
10.00	01000	DIETARY	318,090	27,302	133,470	0	2,267,632	10.00
11.00	01100	CAFETERIA	0	3,426	0	0	2,918,819	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	487	0	16,157	12.00
13.00	01300	NURSING ADMINISTRATION	59,182	4,425	6,425,403	0	8,355,422	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	121,000	144,841	1,425,198	0	3,382,636	14.00
15.00	01500	PHARMACY	115,664	171,710	3,036,264	0	1,805,367	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	4,628	1,522,355	0	2,133,523	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	90,337	0	599,646	22.00
23.00	02300	PARAMED ED PRGM-(EMS)	0	0	21,938	0	52,328	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,710,168	317,375	21,336,427	0	35,744,840	30.00
31.00	03100	INTENSIVE CARE UNIT	329,657	205,175	3,701,935	0	7,912,603	31.00
43.00	04300	NURSERY	116,368	10,629	1,569,568	0	3,178,603	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,855,821	2,611,948	9,851,633	0	22,392,551	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	401,572	145,005	2,461,407	0	4,415,312	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	724,656	2,202,787	8,011,421	0	15,005,005	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	356,529	425,417	1,898,570	0	3,755,878	55.00
57.00	05700	CT SCAN	123,784	986,625	1,229,865	0	2,961,006	57.00
58.00	05800	MRI	151,775	757,501	2,685,607	0	4,681,718	58.00
59.00	05900	CARDIAC CATHETERIZATION	228,459	909,449	1,613,170	0	3,873,228	59.00
60.00	06000	LABORATORY	188,439	297,365	3,979,583	0	12,533,416	60.00
65.00	06500	RESPIRATORY THERAPY	83,694	56,714	1,833,203	0	3,113,109	65.00
66.00	06600	PHYSICAL THERAPY	97,073	20,989	2,173,996	0	2,903,826	66.00
68.00	06800	SPEECH PATHOLOGY	50,894	26,531	819,964	0	1,296,888	68.00
69.00	06900	ELECTROCARDIOLOGY	138,166	74,470	1,063,843	0	1,580,013	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	75,575	24,279	370,062	0	718,109	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	6,408,650	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	9,611,922	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	48,088,884	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	313,503	27,669	586,257	0	1,091,009	76.97
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	705,194	8,728	1,738,283	0	3,299,904	90.01
90.02	09002	WOUND CLINIC	163,273	5,724	648,920	0	1,784,276	90.02
91.00	09100	EMERGENCY	674,600	159,959	6,831,181	0	11,540,711	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	181,398	3,893	190	0	186,461	92.01
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,855,754	12,293,403	107,121,632	-142,237,547	266,456,093	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	11	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,957,027	191,989	352,421	-9,132,986	0	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	143,972	0	3,739,878	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
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)	28,818,307	11,453,590	20,554,606		142,237,547	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.000192	0.917359	0.190996		0.526424	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			7,023		14,925,036	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000065		0.055238	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020

Worksheet B-1

Date/Time Prepared:
3/26/2021 12:42 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			BLDG & FIXT (DV SQUARE FEET)	MVBLE EQUIP (ASSIGNED TIME)				
			1.00	2.00	4.00	5A	5.00	
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: 14-0130

Period:
From 09/01/2019
To 08/31/2020

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	258,176				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,164,923			8.00
9.00	00900	HOUSEKEEPING	2,007	614,405	4,352,197		9.00
10.00	01000	DIETARY	7,481	0	68,575	123,375	10.00
11.00	01100	CAFETERIA	0	0	18,287	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	9,143	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,439	0	0	135,979	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,352	0	45,716	57,000	14.00
15.00	01500	PHARMACY	3,164	0	27,430	64,346	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	100,576	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	4,172	22.00
23.00	02300	PARAMED ED PRGM-(EMS)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	65,927	336,037	2,569,258	90,552	30.00
31.00	03100	INTENSIVE CARE UNIT	8,187	37,201	205,724	10,362	31.00
43.00	04300	NURSERY	2,890	85,277	64,003	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	44,923	20,993	475,450	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,973	25,340	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,552	0	109,719	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	8,724	0	0	0	55.00
57.00	05700	CT SCAN	2,760	0	0	0	57.00
58.00	05800	MRI	3,607	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,379	0	0	0	59.00
60.00	06000	LABORATORY	4,947	0	137,149	0	60.00
65.00	06500	RESPIRATORY THERAPY	964	0	41,145	0	65.00
66.00	06600	PHYSICAL THERAPY	0	5,208	50,288	0	66.00
68.00	06800	SPEECH PATHOLOGY	3,883	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,138	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,836	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	13,904	2,530	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OP PEDS ONC CLINIC	5,887	0	214,867	0	90.01
90.02	09002	WOUND CLINIC	4,089	37,932	0	0	90.02
91.00	09100	EMERGENCY	17,658	0	178,294	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	4,505	0	0	22,461	92.01
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	258,176	1,164,923	4,315,624	123,375	2,159,953
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	36,573	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	0	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	194.01
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)	48,282,514	1,774,671	7,497,749	4,978,557	4,486,859
203.00		Unit cost multiplier (Wkst. B, Part I)	187.013952	1.523423	1.722750	40.353046	2.063053
204.00		Cost to be allocated (per Wkst. B, Part II)	15,017,691	99,196	496,037	911,439	166,457
205.00		Unit cost multiplier (Wkst. B, Part II)	58.168424	0.085152	0.113974	7.387550	0.076537
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020

Worksheet B-1

Date/Time Prepared:
3/26/2021 12:42 am

Cost Center Description			MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS 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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	1,012,080					12.00
13.00	01300	NURSING ADMINISTRATION	0	805,496				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	31,541,431			14.00
15.00	01500	PHARMACY	0	0	0	46,579,430		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	1,918,001,804	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(EMS)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	316,957	627,593	564,261	149,596,785	30.00
31.00	03100	INTENSIVE CARE UNIT	0	68,875	59,818	27,824	26,202,038	31.00
43.00	04300	NURSERY	0	21,780	88	44	8,564,022	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	144,009	5,571,633	117,928	262,383,176	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	44,757	113,219	16,273	30,942,412	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,491	702,385	10,051	163,028,850	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	10,953	0	0	50,876,910	55.00
57.00	05700	CT SCAN	0	938	145,652	5,082	81,052,982	57.00
58.00	05800	MRI	0	856	199,612	3,039	99,501,908	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	14,840	2,841,185	27,955	46,600,830	59.00
60.00	06000	LABORATORY	253,020	0	2,924,927	12,080	207,036,813	60.00
65.00	06500	RESPIRATORY THERAPY	0	402	177,268	329	29,593,988	65.00
66.00	06600	PHYSICAL THERAPY	253,020	0	629	3	13,024,587	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	2,172	0	3,989,986	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5	2,470	4,000	47,726,813	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	3,248	0	2,755,204	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	8,615,909	0	87,086,987	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	9,342,042	0	64,977,123	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	45,747,124	324,661,501	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	7,461	1,230	0	1,338,701	76.97
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	0	35,297	12,278	16,398	25,656,132	90.01
90.02	09002	WOUND CLINIC	0	9,679	27,332	4,590	13,068,427	90.02
91.00	09100	EMERGENCY	506,040	111,229	158,082	22,445	176,779,881	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	1,555,748	92.01
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,012,080	796,529	31,528,772	46,579,426	1,918,001,804	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,393	0	4	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	6,574	12,659	0	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
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)	40,463	13,303,562	5,986,559	3,527,472	173,267	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.039980	16.515988	0.189800	0.075730	0.000090	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,936	619,318	751,039	584,419	11,463	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001913	0.768865	0.023811	0.012547	0.000006	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020

Worksheet B-1

Date/Time Prepared:
3/26/2021 12:42 am

Cost Center Description			MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	12.00	13.00	14.00	15.00	16.00	207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020

Worksheet B-1

Date/Time Prepared:
3/26/2021 12:42 am

Cost Center Description			SOCIAL SERVICE (TIME SPENT)	INTERNS & RESIDENTS		PARAMED ED PRGM-(EMS) (ASSIGNED TIME)		
				SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)			
				17.00	21.00			
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	0					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	9,470,221				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		100			22.00
23.00	02300	PARAMED ED PRGM-(EMS)	0			100		23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	317,375	100	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	205,175	0	0		31.00
43.00	04300	NURSERY	0	10,629	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
45.00	04500	NURSING FACILITY	0	0	0	0		45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,611,948	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	145,005	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,202,787	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	425,417	0	0		55.00
57.00	05700	CT SCAN	0	986,625	0	0		57.00
58.00	05800	MRI	0	757,501	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	909,449	0	0		59.00
60.00	06000	LABORATORY	0	297,365	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	56,714	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	20,989	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	26,531	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	74,470	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	24,279	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0		74.00
76.97	07697	CARDIAC REHABILITATION	0	27,669	0	0		76.97
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	0	8,728	0	0		90.01
90.02	09002	WOUND CLINIC	0	5,724	0	0		90.02
91.00	09100	EMERGENCY	0	159,959	0	100		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	3,893	0	0		92.01
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	9,278,232	100	100		118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	191,989	0	0		192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	0	0		194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0		194.01
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	3,256,661	923,921	79,875		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.343884	9,239.210000	798.750000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	122,197	33,448	2,891		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.012903	334.480000	28.910000		205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020

Worksheet B-1

Date/Time Prepared:
3/26/2021 12:42 am

Cost Center Description			SOCIAL SERVICE (TIME SPENT)	INTERNS & RESIDENTS		PARAMED ED PRGM- (EMS) (ASSIGNED TIME)		
				SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)			
				17.00	21.00			
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: 14-0130

Period:
From 09/01/2019
To 08/31/2020Worksheet C
Part I
Date/Time Prepared:
3/26/2021 12:42 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	82,064,958		82,064,958	0	82,064,958	30.00
31.00	03100	INTENSIVE CARE UNIT	15,770,340		15,770,340	0	15,770,340	31.00
43.00	04300	NURSERY	6,037,982		6,037,982	0	6,037,982	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	47,441,635		47,441,635	0	47,441,635	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,542,157		9,542,157	0	9,542,157	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,735,918		28,735,918	0	28,735,918	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	7,634,337		7,634,337	0	7,634,337	55.00
57.00	05700	CT SCAN	5,133,534		5,133,534	0	5,133,534	57.00
58.00	05800	MRI	8,006,645		8,006,645	0	8,006,645	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,786,646		7,786,646	0	7,786,646	59.00
60.00	06000	LABORATORY	21,144,797		21,144,797	0	21,144,797	60.00
65.00	06500	RESPIRATORY THERAPY	5,145,617	0	5,145,617	0	5,145,617	65.00
66.00	06600	PHYSICAL THERAPY	4,646,006	0	4,646,006	0	4,646,006	66.00
68.00	06800	SPEECH PATHOLOGY	2,754,820	0	2,754,820	0	2,754,820	68.00
69.00	06900	ELECTROCARDIOLOGY	3,245,453		3,245,453	0	3,245,453	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,456,302		1,456,302	0	1,456,302	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,425,455		11,425,455	0	11,425,455	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,450,832		16,450,832	0	16,450,832	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	76,898,238		76,898,238	0	76,898,238	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	4,424,908		4,424,908	0	4,424,908	76.97
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	7,199,428		7,199,428	0	7,199,428	90.01
90.02	09002	WOUND CLINIC	3,746,287		3,746,287	0	3,746,287	90.02
91.00	09100	EMERGENCY	23,574,087		23,574,087	0	23,574,087	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	16,585,154		16,585,154	0	16,585,154	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	2,033,644		2,033,644	0	2,033,644	92.01
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	418,885,180	0	418,885,180	0	418,885,180	200.00
201.00		Less Observation Beds	16,585,154		16,585,154		16,585,154	201.00
202.00		Total (see instructions)	402,300,026	0	402,300,026	0	402,300,026	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020Worksheet C
Part I
Date/Time Prepared:
3/26/2021 12:42 am

			Title XVIII		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	120,531,416		120,531,416		30.00
31.00	03100	INTENSIVE CARE UNIT	26,202,038		26,202,038		31.00
43.00	04300	NURSERY	8,564,022		8,564,022		43.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
45.00	04500	NURSING FACILITY	0		0		45.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	70,805,414	191,577,762	262,383,176	0.180811	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,178,477	1,763,935	30,942,412	0.308384	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,222,627	145,806,223	163,028,850	0.176263	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	998,997	49,877,913	50,876,910	0.150055	0.000000
57.00	05700	CT SCAN	27,882,865	53,170,117	81,052,982	0.063336	0.000000
58.00	05800	MRI	12,848,998	86,652,910	99,501,908	0.080467	0.000000
59.00	05900	CARDIAC CATHETERIZATION	23,800,169	22,800,661	46,600,830	0.167092	0.000000
60.00	06000	LABORATORY	81,932,176	125,104,637	207,036,813	0.102131	0.000000
65.00	06500	RESPIRATORY THERAPY	24,933,144	4,660,844	29,593,988	0.173874	0.000000
66.00	06600	PHYSICAL THERAPY	3,805	13,020,782	13,024,587	0.356710	0.000000
68.00	06800	SPEECH PATHOLOGY	1,303,024	2,686,962	3,989,986	0.690434	0.000000
69.00	06900	ELECTROCARDIOLOGY	15,203,080	32,523,733	47,726,813	0.068001	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	393,107	2,362,097	2,755,204	0.528564	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	33,278,378	53,808,609	87,086,987	0.131196	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	34,026,743	30,950,380	64,977,123	0.253179	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	30,960,143	293,701,358	324,661,501	0.236857	0.000000
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000
76.97	07697	CARDIAC REHABILITATION	2,779	1,335,922	1,338,701	3.305374	0.000000
	OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	133,150	25,522,982	25,656,132	0.280612	0.000000
90.02	09002	WOUND CLINIC	134,278	12,934,149	13,068,427	0.286667	0.000000
91.00	09100	EMERGENCY	35,048,666	141,731,215	176,779,881	0.133353	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	7,541,090	21,524,279	29,065,369	0.570616	0.000000
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	117,670	1,438,078	1,555,748	1.307181	0.000000
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
200.00		Subtotal (see instructions)	603,046,256	1,314,955,548	1,918,001,804		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	603,046,256	1,314,955,548	1,918,001,804		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0130

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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.180811		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.308384		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176263		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.150055		55.00
57.00	05700	CT SCAN	0.063336		57.00
58.00	05800	MRI	0.080467		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.167092		59.00
60.00	06000	LABORATORY	0.102131		60.00
65.00	06500	RESPIRATORY THERAPY	0.173874		65.00
66.00	06600	PHYSICAL THERAPY	0.356710		66.00
68.00	06800	SPEECH PATHOLOGY	0.690434		68.00
69.00	06900	ELECTROCARDIOLOGY	0.068001		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.528564		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.131196		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.253179		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.236857		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.97	07697	CARDIAC REHABILITATION	3.305374		76.97
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OP PEDS ONC CLINIC	0.280612		90.01
90.02	09002	WOUND CLINIC	0.286667		90.02
91.00	09100	EMERGENCY	0.133353		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.570616		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1.307181		92.01
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY			101.00
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: 14-0130

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				Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	82,064,958		82,064,958	0	82,064,958	30.00	
31.00	03100	INTENSIVE CARE UNIT	15,770,340		15,770,340	0	15,770,340	31.00	
43.00	04300	NURSERY	6,037,982		6,037,982	0	6,037,982	43.00	
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00	
45.00	04500	NURSING FACILITY	0		0	0	0	45.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	47,441,635		47,441,635	0	47,441,635	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,542,157		9,542,157	0	9,542,157	52.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,735,918		28,735,918	0	28,735,918	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	7,634,337		7,634,337	0	7,634,337	55.00	
57.00	05700	CT SCAN	5,133,534		5,133,534	0	5,133,534	57.00	
58.00	05800	MRI	8,006,645		8,006,645	0	8,006,645	58.00	
59.00	05900	CARDIAC CATHETERIZATION	7,786,646		7,786,646	0	7,786,646	59.00	
60.00	06000	LABORATORY	21,144,797		21,144,797	0	21,144,797	60.00	
65.00	06500	RESPIRATORY THERAPY	5,145,617	0	5,145,617	0	5,145,617	65.00	
66.00	06600	PHYSICAL THERAPY	4,646,006	0	4,646,006	0	4,646,006	66.00	
68.00	06800	SPEECH PATHOLOGY	2,754,820	0	2,754,820	0	2,754,820	68.00	
69.00	06900	ELECTROCARDIOLOGY	3,245,453		3,245,453	0	3,245,453	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	1,456,302		1,456,302	0	1,456,302	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,425,455		11,425,455	0	11,425,455	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,450,832		16,450,832	0	16,450,832	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	76,898,238		76,898,238	0	76,898,238	73.00	
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00	
76.97	07697	CARDIAC REHABILITATION	4,424,908		4,424,908	0	4,424,908	76.97	
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	OP PEDS ONC CLINIC	7,199,428		7,199,428	0	7,199,428	90.01	
90.02	09002	WOUND CLINIC	3,746,287		3,746,287	0	3,746,287	90.02	
91.00	09100	EMERGENCY	23,574,087		23,574,087	0	23,574,087	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	16,585,154		16,585,154	0	16,585,154	92.00	
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	2,033,644		2,033,644	0	2,033,644	92.01	
OTHER REIMBURSABLE COST CENTERS									
101.00	10100	HOME HEALTH AGENCY	0		0	0	0	101.00	
200.00		Subtotal (see instructions)	418,885,180	0	418,885,180	0	418,885,180	200.00	
201.00		Less Observation Beds	16,585,154		16,585,154	0	16,585,154	201.00	
202.00		Total (see instructions)	402,300,026	0	402,300,026	0	402,300,026	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0130

Period:
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			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	120,531,416		120,531,416		30.00
31.00	03100	INTENSIVE CARE UNIT	26,202,038		26,202,038		31.00
43.00	04300	NURSERY	8,564,022		8,564,022		43.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
45.00	04500	NURSING FACILITY	0		0		45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	70,805,414	191,577,762	262,383,176	0.180811	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,178,477	1,763,935	30,942,412	0.308384	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,222,627	145,806,223	163,028,850	0.176263	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	998,997	49,877,913	50,876,910	0.150055	0.000000
57.00	05700	CT SCAN	27,882,865	53,170,117	81,052,982	0.063336	0.000000
58.00	05800	MRI	12,848,998	86,652,910	99,501,908	0.080467	0.000000
59.00	05900	CARDIAC CATHETERIZATION	23,800,169	22,800,661	46,600,830	0.167092	0.000000
60.00	06000	LABORATORY	81,932,176	125,104,637	207,036,813	0.102131	0.000000
65.00	06500	RESPIRATORY THERAPY	24,933,144	4,660,844	29,593,988	0.173874	0.000000
66.00	06600	PHYSICAL THERAPY	3,805	13,020,782	13,024,587	0.356710	0.000000
68.00	06800	SPEECH PATHOLOGY	1,303,024	2,686,962	3,989,986	0.690434	0.000000
69.00	06900	ELECTROCARDIOLOGY	15,203,080	32,523,733	47,726,813	0.068001	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	393,107	2,362,097	2,755,204	0.528564	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	33,278,378	53,808,609	87,086,987	0.131196	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	34,026,743	30,950,380	64,977,123	0.253179	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	30,960,143	293,701,358	324,661,501	0.236857	0.000000
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000
76.97	07697	CARDIAC REHABILITATION	2,779	1,335,922	1,338,701	3.305374	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OP PEDS ONC CLINIC	133,150	25,522,982	25,656,132	0.280612	0.000000
90.02	09002	WOUND CLINIC	134,278	12,934,149	13,068,427	0.286667	0.000000
91.00	09100	EMERGENCY	35,048,666	141,731,215	176,779,881	0.133353	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	7,541,090	21,524,279	29,065,369	0.570616	0.000000
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	117,670	1,438,078	1,555,748	1.307181	0.000000
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
200.00		Subtotal (see instructions)	603,046,256	1,314,955,548	1,918,001,804		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	603,046,256	1,314,955,548	1,918,001,804		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0130

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Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
44.00	04400	SKILLED NURSING FACILITY				44.00
45.00	04500	NURSING FACILITY				45.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	0.000000			90.01
90.02	09002	WOUND CLINIC	0.000000			90.02
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000			92.01
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY				101.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020Worksheet D
Part I
Date/Time Prepared:
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			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	10,113,078	0	10,113,078	36,611	276.23	30.00	
31.00	INTENSIVE CARE UNIT	1,596,161		1,596,161	3,762	424.29	31.00	
43.00	NURSERY	502,954		502,954	4,001	125.71	43.00	
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00	
45.00	NURSING FACILITY	0		0	0	0.00	45.00	
200.00	Total (lines 30 through 199)	12,212,193		12,212,193	44,374		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	10,014	2,766,167					30.00
31.00	INTENSIVE CARE UNIT	2,603	1,104,427					31.00
43.00	NURSERY	0	0					43.00
44.00	SKILLED NURSING FACILITY	0	0					44.00
45.00	NURSING FACILITY	0	0					45.00
200.00	Total (lines 30 through 199)	12,617	3,870,594					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020Worksheet D
Part II
Date/Time Prepared:
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Cost Center Description			Title XVIII		Hospital	PPS	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,429,301	262,383,176	0.032126	28,492,033	915,335
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,403,469	30,942,412	0.045357	15,874	720
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,180,716	163,028,850	0.031778	7,539,208	239,581
55.00	05500	RADIOLOGY-THERAPEUTIC	1,473,761	50,876,910	0.028967	390,917	11,324
57.00	05700	CT SCAN	1,359,557	81,052,982	0.016774	11,929,366	200,103
58.00	05800	MRI	1,325,970	99,501,908	0.013326	4,816,534	64,185
59.00	05900	CARDIAC CATHETERIZATION	1,672,316	46,600,830	0.035886	9,742,687	349,626
60.00	06000	LABORATORY	1,538,672	207,036,813	0.007432	30,888,969	229,567
65.00	06500	RESPIRATORY THERAPY	376,986	29,593,988	0.012739	12,034,996	153,314
66.00	06600	PHYSICAL THERAPY	287,631	13,024,587	0.022084	3,170	70
68.00	06800	SPEECH PATHOLOGY	374,667	3,989,986	0.093902	732,268	68,761
69.00	06900	ELECTROCARDIOLOGY	536,983	47,726,813	0.011251	7,040,091	79,208
70.00	07000	ELECTROENCEPHALOGRAPHY	245,036	2,755,204	0.088936	104,082	9,257
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	559,677	87,086,987	0.006427	12,686,169	81,534
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	753,785	64,977,123	0.011601	16,871,602	195,727
73.00	07300	DRUGS CHARGED TO PATIENTS	3,232,163	324,661,501	0.009955	12,218,581	121,636
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0
76.97	07697	CARDIAC REHABILITATION	1,215,194	1,338,701	0.907741	2,364	2,146
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OP PEDS ONC CLINIC	1,304,147	25,656,132	0.050832	89,268	4,538
90.02	09002	WOUND CLINIC	517,716	13,068,427	0.039616	107,162	4,245
91.00	09100	EMERGENCY	2,611,952	176,779,881	0.014775	12,761,371	188,549
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,043,838	29,065,369	0.070319	3,376,063	237,401
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	623,295	1,555,748	0.400640	34,474	13,812
200.00		Total (lines 50 through 199)	37,066,832	1,762,704,328		171,877,249	3,170,639

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0130		Period: From 09/01/2019 To 08/31/2020		Worksheet D Part III Date/Time Prepared: 3/26/2021 12:42 am		
					Title XVIII		Hospital		PPS		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost				
			1A	1.00	2A	2.00	3.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00		
43.00	04300	NURSERY	0	0	0	0	0	0	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	44.00		
45.00	04500	NURSING FACILITY	0	0	0	0	0	0	45.00		
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	200.00		
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days				
			4.00	5.00	6.00	7.00	8.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	36,611	0.00	10,014		30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	3,762	0.00	2,603		31.00		
43.00	04300	NURSERY	0	0	4,001	0.00	0		43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0.00	0		44.00		
45.00	04500	NURSING FACILITY	0	0	0	0.00	0		45.00		
200.00		Total (lines 30 through 199)	0	0	44,374		12,617		200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)								
			9.00								
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0								30.00
31.00	03100	INTENSIVE CARE UNIT	0								31.00
43.00	04300	NURSERY	0								43.00
44.00	04400	SKILLED NURSING FACILITY	0								44.00
45.00	04500	NURSING FACILITY	0								45.00
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0130

Period:
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Cost Center Description			Title XVIII		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	0	0	0	0	0	90.01
90.02	09002	WOUND CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	79,875	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
200.00		Total (lines 50 through 199)	0	0	0	0	79,875	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0130

Period:
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Part IV
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				Title XVIII		Hospital	PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	262,383,176	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	30,942,412	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	163,028,850	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	50,876,910	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	81,052,982	0.000000	57.00
58.00	05800	MRI	0	0	0	99,501,908	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	46,600,830	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	207,036,813	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	29,593,988	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	13,024,587	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,989,986	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	47,726,813	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,755,204	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	87,086,987	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	64,977,123	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	324,661,501	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	1,338,701	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	0	0	0	25,656,132	0.000000	90.01
90.02	09002	WOUND CLINIC	0	0	0	13,068,427	0.000000	90.02
91.00	09100	EMERGENCY	0	79,875	79,875	176,779,881	0.000452	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	29,065,369	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	1,555,748	0.000000	92.01
200.00		Total (lines 50 through 199)	0	79,875	79,875	1,762,704,328		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020

Worksheet D
Part IV
Date/Time Prepared:
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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								
50.00	05000	OPERATING ROOM	0.000000	28,492,033	0	44,370,287	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	15,874	0	20,250	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	7,539,208	0	38,918,658	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	390,917	0	19,002,946	0	55.00
57.00	05700	CT SCAN	0.000000	11,929,366	0	14,503,740	0	57.00
58.00	05800	MRI	0.000000	4,816,534	0	24,586,303	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	9,742,687	0	10,222,992	0	59.00
60.00	06000	LABORATORY	0.000000	30,888,969	0	21,921,947	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	12,034,996	0	1,778,399	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	3,170	0	287,538	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	732,268	0	271,339	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	7,040,091	0	10,881,620	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	104,082	0	732,700	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	12,686,169	0	13,265,532	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	16,871,602	0	10,645,245	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	12,218,581	0	118,643,029	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	2,364	0	686,780	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	0.000000	89,268	0	10,333,114	0	90.01
90.02	09002	WOUND CLINIC	0.000000	107,162	0	6,209,235	0	90.02
91.00	09100	EMERGENCY	0.000452	12,761,371	5,768	19,390,346	8,764	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	3,376,063	0	7,111,612	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	34,474	0	318,912	0	92.01
200.00		Total (lines 50 through 199)		171,877,249	5,768	374,102,524	8,764	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020Worksheet D
Part V
Date/Time Prepared:
3/26/2021 12:42 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.180811	44,370,287	0	0	8,022,636	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.308384	20,250	0	0	6,245	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176263	38,918,658	0	0	6,859,919	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.150055	19,002,946	0	0	2,851,487	55.00
57.00	05700	CT SCAN	0.063336	14,503,740	0	0	918,609	57.00
58.00	05800	MRI	0.080467	24,586,303	0	0	1,978,386	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.167092	10,222,992	0	0	1,708,180	59.00
60.00	06000	LABORATORY	0.102131	21,921,947	0	0	2,238,910	60.00
65.00	06500	RESPIRATORY THERAPY	0.173874	1,778,399	0	0	309,217	65.00
66.00	06600	PHYSICAL THERAPY	0.356710	287,538	0	0	102,568	66.00
68.00	06800	SPEECH PATHOLOGY	0.690434	271,339	0	0	187,342	68.00
69.00	06900	ELECTROCARDIOLOGY	0.068001	10,881,620	0	0	739,961	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.528564	732,700	0	0	387,279	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.131196	13,265,532	0	0	1,740,385	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.253179	10,645,245	0	0	2,695,152	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.236857	118,643,029	0	37,278	28,101,432	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	3.305374	686,780	0	0	2,270,065	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OP PEDS ONC CLINIC	0.280612	10,333,114	0	0	2,899,596	90.01
90.02	09002	WOUND CLINIC	0.286667	6,209,235	0	0	1,779,983	90.02
91.00	09100	EMERGENCY	0.133353	19,390,346	0	0	2,585,761	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.570616	7,111,612	0	0	4,058,000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1.307181	318,912	0	0	416,876	92.01
200.00		Subtotal (see instructions)		374,102,524	0	37,278	72,857,989	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		374,102,524	0	37,278	72,857,989	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020Worksheet D
Part V
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			Title XVIII		Hospital	PPS
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,830		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
	OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OP PEDS ONC CLINIC	0	0		90.01
90.02	09002	WOUND CLINIC	0	0		90.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
200.00		Subtotal (see instructions)	0	8,830		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	8,830		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0130	Period: From 09/01/2019 To 08/31/2020	Worksheet D-1 Date/Time Prepared: 3/26/2021 12:42 am
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		36,611	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		36,611	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)		29,212	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		10,014	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)		82,064,958	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)		82,064,958	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)		82,064,958	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)		2,241.54	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		22,446,782	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)		22,446,782	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020

Worksheet D-1

Date/Time Prepared:
3/26/2021 12:42 am

		Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	15,770,340	3,762	4,192.01	2,603	10,911,802
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					28,169,737
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					61,528,321
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					3,870,594
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					3,176,407
52.00	Total Program excludable cost (sum of lines 50 and 51)					7,047,001
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					54,481,320
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					7,399
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,241.54
89.00	Observation bed cost (line 87 x line 88) (see instructions)					16,585,154

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020

Worksheet D-1

Date/Time Prepared:
3/26/2021 12:42 am

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	10,113,078	82,064,958	0.123233	16,585,154	2,043,838	90.00
91.00 Nursing School cost	0	82,064,958	0.000000	16,585,154	0	91.00
92.00 Allied health cost	0	82,064,958	0.000000	16,585,154	0	92.00
93.00 All other Medical Education	0	82,064,958	0.000000	16,585,154	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0130	Period: From 09/01/2019 To 08/31/2020	Worksheet D-1 Date/Time Prepared: 3/26/2021 12:42 am	
		Title XIX	Hospital	Cost	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		36,611	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		36,611	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)		29,212	4.00	
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00	
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00	
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		2,209	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)		4,001	15.00	
16.00	Nursery days (title V or XIX only)		466	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)		82,064,958	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)		82,064,958	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)		82,064,958	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)		2,241.54	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,951,562	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)		4,951,562	41.00	

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0130	Period: From 09/01/2019 To 08/31/2020	Worksheet D-1 Date/Time Prepared: 3/26/2021 12:42 am	
Title XIX			Hospital		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	6,037,982	4,001	1,509.12	466	703,250	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	15,770,340	3,762	4,192.01	87	364,705	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)					6,019,517	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					7,399	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,241.54	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					16,585,154	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020

Worksheet D-1

Date/Time Prepared:
3/26/2021 12:42 am

Cost Center Description		Title XIX		Hospital		Cost	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	10,113,078	82,064,958	0.123233	16,585,154	2,043,838	90.00
91.00	Nursing School cost	0	82,064,958	0.000000	16,585,154	0	91.00
92.00	Allied health cost	0	82,064,958	0.000000	16,585,154	0	92.00
93.00	All other Medical Education	0	82,064,958	0.000000	16,585,154	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0130	Period: From 09/01/2019 To 08/31/2020	Worksheet D-3 Date/Time Prepared: 3/26/2021 12:42 am	
			Title XVIII	Hospital	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		43,710,554		30.00
31.00	03100	INTENSIVE CARE UNIT		10,457,455		31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.180811	28,492,033	5,151,673	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.308384	15,874	4,895	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176263	7,539,208	1,328,883	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.150055	390,917	58,659	55.00
57.00	05700	CT SCAN	0.063336	11,929,366	755,558	57.00
58.00	05800	MRI	0.080467	4,816,534	387,572	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.167092	9,742,687	1,627,925	59.00
60.00	06000	LABORATORY	0.102131	30,888,969	3,154,721	60.00
65.00	06500	RESPIRATORY THERAPY	0.173874	12,034,996	2,092,573	65.00
66.00	06600	PHYSICAL THERAPY	0.356710	3,170	1,131	66.00
68.00	06800	SPEECH PATHOLOGY	0.690434	732,268	505,583	68.00
69.00	06900	ELECTROCARDIOLOGY	0.068001	7,040,091	478,733	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.528564	104,082	55,014	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.131196	12,686,169	1,664,375	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.253179	16,871,602	4,271,535	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.236857	12,218,581	2,894,056	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	3.305374	2,364	7,814	76.97
OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	0.280612	89,268	25,050	90.01
90.02	09002	WOUND CLINIC	0.286667	107,162	30,720	90.02
91.00	09100	EMERGENCY	0.133353	12,761,371	1,701,767	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.570616	3,376,063	1,926,436	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1.307181	34,474	45,064	92.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		171,877,249	28,169,737	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		171,877,249		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0130	Period: From 09/01/2019 To 08/31/2020	Worksheet E Part A Date/Time Prepared: 3/26/2021 12:42 am	
		Title XVIII	Hospital	PPS	
				1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments		0	1.00	
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		2,821,406	1.01	
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		28,158,350	1.02	
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03	
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04	
2.00	Outlier payments for discharges. (see instructions)			2.00	
2.01	Outlier reconciliation amount		0	2.01	
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02	
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		147,087	2.03	
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		1,217,279	2.04	
3.00	Managed Care Simulated Payments		5,736,712	3.00	
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		109.19	4.00	
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		23.92	5.00	
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00	
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00	
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01	
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00	
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01	
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02	
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		23.92	9.00	
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		23.92	10.00	
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00	
12.00	Current year allowable FTE (see instructions)		23.92	12.00	
13.00	Total allowable FTE count for the prior year.		24.40	13.00	
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		23.71	14.00	
15.00	Sum of lines 12 through 14 divided by 3.		24.01	15.00	
16.00	Adjustment for residents in initial years of the program		0.00	16.00	
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00	
18.00	Adjusted rolling average FTE count		24.01	18.00	
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.219892	19.00	
20.00	Prior year resident to bed ratio (see instructions)		0.225508	20.00	
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.219892	21.00	
22.00	IME payment adjustment (see instructions)		3,505,855	22.00	
22.01	IME payment adjustment - Managed Care (see instructions)		649,201	22.01	
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00	
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00	
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00	
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00	
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00	
28.00	IME add-on adjustment amount (see instructions)		0	28.00	
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01	
29.00	Total IME payment (sum of lines 22 and 28)		3,505,855	29.00	
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		649,201	29.01	
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.23	30.00	
31.00	Percentage of Medicaid patient days (see instructions)		17.83	31.00	
32.00	Sum of lines 30 and 31		20.06	32.00	
33.00	Allowable disproportionate share percentage (see instructions)		5.79	33.00	
34.00	Disproportionate share adjustment (see instructions)		448,432	34.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0130	Period: From 09/01/2019 To 08/31/2020	Worksheet E Part A Date/Time Prepared: 3/26/2021 12:42 am
		Title XVIII	Hospital	PPS
			Prior to 10/1	On/After 10/1
			1.00	2.00
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	8,272,872,447	0	35.00
35.01	Factor 3 (see instructions)	0.000182009	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,505,737	2,052,195	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	123,760	1,883,983	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,007,743		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		40.00
			Before 1/1	On/After 1/1
			1.00	1.01
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	38,306,152		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		38,955,353	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,957,790	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		527,895	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		138,098	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		5,768	58.00
59.00	Total (sum of amounts on lines 49 through 58)		42,584,904	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		42,584,904	61.00
62.00	Deductibles billed to program beneficiaries		3,232,240	62.00
63.00	Coinsurance billed to program beneficiaries		57,211	63.00
64.00	Allowable bad debts (see instructions)		333,802	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		216,971	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		207,328	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		39,512,424	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		269,122	70.93
70.94	HRR adjustment amount (see instructions)		-724,153	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0130	Period: From 09/01/2019 To 08/31/2020	Worksheet E Part A Date/Time Prepared: 3/26/2021 12:42 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		415,962	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		38,641,431	71.00
71.01	Sequestration adjustment (see instructions)		513,931	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		38,226,820	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-99,320	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,452,046	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
3/26/2021 12:42 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,821,406	0	2,821,406		2,821,406
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	28,158,350	0		28,158,350	28,158,350
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	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
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	147,087	0	147,087		147,087
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	1,217,279	0		1,217,279	1,217,279
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	5,736,712	0	520,368	5,216,344	5,736,712
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.219892	0.219892	0.219892	0.219892	
6.00	IME payment adjustment (see instructions)	22.00	3,505,855	0	319,287	3,186,568	3,505,855
6.01	IME payment adjustment for managed care (see instructions)	22.01	649,201	0	58,888	590,313	649,201
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	
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	3,505,855	0	319,287	3,186,568	3,505,855
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	649,201	0	58,888	590,313	649,201
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0579	0.0579	0.0579	0.0579	
11.00	Disproportionate share adjustment (see instructions)	34.00	448,432	0	40,840	407,592	448,432
11.01	Uncompensated care payments	36.00	2,007,743	0	28,296	1,031,941	1,060,237
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	38,306,152	0	3,356,916	34,949,236	38,306,152
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	38,955,353	0	3,415,804	35,539,549	38,955,353
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,957,790	0	277,327	2,680,463	2,957,790

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
3/26/2021 12:42 am

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	138,098	0	1,500	136,598	138,098	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	3,694,631	38,356,610	42,051,241	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	2,452,638	0	229,534	2,223,104	2,452,638	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	215,496	0	20,685	194,811	215,496	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0767	0.0767	0.0767	0.0767		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	188,117	0	17,605	170,512	188,117	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0414	0.0414	0.0414	0.0414		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	101,539	0	9,503	92,036	101,539	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2,957,790	0	277,327	2,680,463	2,957,790	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5			Provider CCN: 14-0130		Period: From 09/01/2019 To 08/31/2020		Worksheet E Part A Exhibit 5 Date/Time Prepared: 3/26/2021 12:42 am	
			Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)		
		0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00						1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,821,406	2,821,406		2,821,406		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	28,158,350		28,158,350	28,158,350		1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0		1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0		1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0		2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	147,087	147,087		147,087		2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	1,217,279		1,217,279	1,217,279		2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0		3.00
4.00	Managed care simulated payments	3.00	5,736,712	520,368	5,216,344	5,736,712		4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.219892	0.219892	0.219892			5.00
6.00	IME payment adjustment (see instructions)	22.00	3,505,855	319,287	3,186,568	3,505,855		6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	649,201	58,888	590,313	649,201		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	3,505,855	319,287	3,186,568	3,505,855		9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	649,201	58,888	590,313	649,201		9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0579	0.0579	0.0579			10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	448,432	40,840	407,592	448,432		11.00
11.01	Uncompensated care payments	36.00	2,007,743	123,760	1,883,983	2,007,743		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	38,306,152	3,452,380	34,853,772	38,306,152		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	38,955,353	3,511,268	35,444,085	38,955,353		15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,957,790	277,327	2,680,463	2,957,790		16.00
17.00	Special add-on payments for new technologies	54.00	138,098	1,500	136,598	138,098		17.00
17.01	Net organ acquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0		17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0		18.00
19.00	SUBTOTAL			3,790,095	38,261,146	42,051,241		19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
3/26/2021 12:42 am

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	2,452,638	229,534	2,223,104	2,452,638	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	215,496	20,685	194,811	215,496	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	0.0767	0.0767	0.0767		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	188,117	17,605	170,512	188,117	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0414	0.0414	0.0414		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	101,539	9,503	92,036	101,539	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2,957,790	277,327	2,680,463	2,957,790	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	269,122	13,195	255,927	269,122	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	-724,153	-84,687	-639,466	-724,153	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		37,186	378,776	415,962	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0130	Period: From 09/01/2019 To 08/31/2020	Worksheet E Part B Date/Time Prepared: 3/26/2021 12:42 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		8,830	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		72,849,225	2.00
3.00	OPPS payments		43,722,592	3.00
4.00	Outlier payment (see instructions)		872,977	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		8,764	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		8,830	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		37,278	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)		37,278	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)		37,278	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		28,448	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)		8,830	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)		44,604,333	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		142,526	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		7,126,317	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)		37,344,320	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		625,091	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)		37,969,411	30.00
31.00	Primary payer payments		9,705	31.00
32.00	Subtotal (line 30 minus line 31)		37,959,706	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)		504,554	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		327,960	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		334,842	36.00
37.00	Subtotal (see instructions)		38,287,666	37.00
38.00	MSP-LCC reconciliation amount from PS&R		578	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		38,287,088	40.00
40.01	Sequestration adjustment (see instructions)		509,218	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		37,817,443	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		-39,573	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020Worksheet E-1
Part I
Date/Time Prepared:
3/26/2021 12:42 am

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		37,402,823		36,833,503	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		672,092		959,087	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	05/04/2020	151,905	05/04/2020	24,853	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
3.06			0		0	3.06
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)		151,905		24,853	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)		38,226,820		37,817,443	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		99,320		39,573	6.02
7.00	Total Medicare program liability (see instructions)		38,127,500		37,777,870	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020Worksheet E-1
Part II
Date/Time Prepared:
3/26/2021 12:42 am

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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0130	Period: From 09/01/2019 To 08/31/2020	Worksheet E-3 Part VII Date/Time Prepared: 3/26/2021 12:42 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services	6,019,517			1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)	0			3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	6,019,517		0	4.00
5.00	Inpatient primary payer payments	0			5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	6,019,517		0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges	0			8.00
9.00	Ancillary service charges	0		0	9.00
10.00	Organ acquisition charges, net of revenue	0			10.00
11.00	Incentive from target amount computation	0			11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0		0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0		0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0		0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000		0.000000	15.00
16.00	Total customary charges (see instructions)	0		0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0		0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	6,019,517		0	18.00
19.00	Interns and Residents (see instructions)	0		0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0		0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments	0		0	22.00
23.00	Outlier payments	0		0	23.00
24.00	Program capital payments	0			24.00
25.00	Capital exception payments (see instructions)	0			25.00
26.00	Routine and Ancillary service other pass through costs	0		0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0			28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0		0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)	6,019,517		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0		0	31.00
32.00	Deductibles	0			32.00
33.00	Coinurance	0			33.00
34.00	Allowable bad debts (see instructions)	0			34.00
35.00	Utilization review	0			35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0		0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		0	37.00
38.00	Subtotal (line 36 ± line 37)	0		0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0			39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0		0	40.00
41.00	Interim payments	0		0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0		0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0		0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0130		Period: From 09/01/2019 To 08/31/2020		Worksheet E-4 Date/Time Prepared: 3/26/2021 12:42 am	
		Title XVIII		Hospital		PPS	
						1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT							
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.					24.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)					0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA					0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)					0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))					0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)					0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)					0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)					24.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)					23.92	6.00
7.00	Enter the lesser of line 5 or line 6					23.92	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.	23.92	0.00	23.92		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.	23.92	0.00	23.92		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	23.92	0.00	23.92		11.00	
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	24.40	0.00	24.40		12.00	
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	23.71	0.00	23.71		13.00	
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	24.01	0.00	24.01		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	24.01	0.00	24.01		17.00	
18.00	Per resident amount	106,830.77	0.00	106,830.77		18.00	
19.00	Approved amount for resident costs	2,565,007	0	2,565,007		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)					2,565,007	25.00
		Inpatient Part A	Managed Care Prior to 1/1	Managed Care On or after 1/1	Total		
		1.00	2.00	2.01	3.00		
COMPUTATION OF PROGRAM PATIENT LOAD							
26.00	Inpatient Days (see instructions)	12,617	861	1,785			26.00
27.00	Total Inpatient Days (see instructions)	33,543	33,543	33,543			27.00
28.00	Ratio of inpatient days to total inpatient days	0.376144	0.025669	0.053215			28.00
29.00	Program direct GME amount	964,812	65,841	136,497	1,167,150		29.00
29.01	Percent reduction for MA DGME		7.00	7.00			29.01
30.00	Reduction for direct GME payments for Medicare Advantage		4,609	9,555	14,164		30.00
31.00	Net Program direct GME amount				1,152,986		31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0130	Period: From 09/01/2019 To 08/31/2020	Worksheet E-4 Date/Time Prepared: 3/26/2021 12:42 am	
		Title XVIII	Hospital	PPS	
				1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			0	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)			61,528,321	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)			0	39.00
40.00	Primary payer payments (see instructions)			0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			61,528,321	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			72,866,819	42.00
43.00	Primary payer payments (see instructions)			9,705	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			72,857,114	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			134,385,435	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.457850	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.542150	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			1,152,986	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			527,895	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			625,091	50.00

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

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020

Worksheet G

Date/Time Prepared:

3/26/2021 12:42 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	1,001,198	28,386,889	31,814,186	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	359,262	0	0	0	3.00
4.00	Accounts receivable	43,567,953	0	0	0	4.00
5.00	Other receivable	526,858	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-23,627,365	0	0	0	6.00
7.00	Inventory	7,754,597	0	0	0	7.00
8.00	Prepaid expenses	850,349	0	0	0	8.00
9.00	Other current assets	8,213,944	0	0	0	9.00
10.00	Due from other funds	67,760,416	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	106,407,212	28,386,889	31,814,186	0	11.00
FIXED ASSETS						
12.00	Land	53,023,598	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	565,269,850	0	0	0	15.00
16.00	Accumulated depreciation	-122,990,699	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	119,748,233	0	0	0	19.00
20.00	Accumulated depreciation	-67,813,630	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)	547,237,352	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	70,287,341	1,591,475	2,300,370	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	4	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	70,287,345	1,591,475	2,300,370	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	723,931,909	29,978,364	34,114,556	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	6,757,292	0	0	0	37.00
38.00	Salaries, wages, and fees payable	11,838,743	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	61,960,395	0	0	0	43.00
44.00	Other current liabilities	15,543,943	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	96,100,373	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	4	0	0	0	48.00
49.00	Other long term liabilities	79,389,394	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	79,389,398	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	175,489,771	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	548,442,138				52.00
53.00	Specific purpose fund		29,978,364			53.00
54.00	Donor created - endowment fund balance - restricted			34,114,556		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	548,442,138	29,978,364	34,114,556	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	723,931,909	29,978,364	34,114,556	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020

Worksheet G-1

Date/Time Prepared:
3/26/2021 12:42 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		557,323,406		28,386,889		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-22,523,505				2.00
3.00	Total (sum of line 1 and line 2)		534,799,901		28,386,889		3.00
4.00	ASSET RELEA TO FINANCE PROP AND EQUI	2,378,909		0		0	4.00
5.00	OTHER	8,500		0		0	5.00
6.00	RECLASSIFICATIONS	0		48,497		1,000,000	6.00
7.00	GIFTS AND OTHER REVENUE	0		3,617,833		1,300,370	7.00
8.00	INTERCOMPANY SETTLEMENTS	23,237,018		0		0	8.00
9.00	INVESTMENT INCOM & CHG IN NET ASSETS	0		3,261,958		0	9.00
10.00	Total additions (sum of line 4-9)		25,624,427		6,928,288		10.00
11.00	Subtotal (line 3 plus line 10)		560,424,328		35,315,177		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	OPERATING EXPENSES	0		1,924,514		0	13.00
14.00	PROPERTY ADDITIONS	0		2,378,909		0	14.00
15.00	RECLASSIFICATION	0		1,008,500		0	15.00
16.00	OTHER	0		24,890		0	16.00
17.00	POST BENE TO RELATED TO NET PENSION	11,982,190		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		11,982,190		5,336,813		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		548,442,138		29,978,364		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	31,814,186		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)	31,814,186		0			3.00
4.00	ASSET RELEA TO FINANCE PROP AND EQUI		0				4.00
5.00	OTHER		0				5.00
6.00	RECLASSIFICATIONS		0				6.00
7.00	GIFTS AND OTHER REVENUE		0				7.00
8.00	INTERCOMPANY SETTLEMENTS		0				8.00
9.00	INVESTMENT INCOM & CHG IN NET ASSETS		0				9.00
10.00	Total additions (sum of line 4-9)	2,300,370		0			10.00
11.00	Subtotal (line 3 plus line 10)	34,114,556		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00	OPERATING EXPENSES		0				13.00
14.00	PROPERTY ADDITIONS		0				14.00
15.00	RECLASSIFICATION		0				15.00
16.00	OTHER		0				16.00
17.00	POST BENE TO RELATED TO NET PENSION		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)	34,114,556		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
3/26/2021 12:42 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	106,935,367		106,935,367	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	0		0	7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	106,935,367		106,935,367	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	18,974,453		18,974,453	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)	18,974,453		18,974,453	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	125,909,820		125,909,820	17.00
18.00	Ancillary services	463,159,245	0	463,159,245	18.00
19.00	Outpatient services		1,328,932,738	1,328,932,738	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		0	0	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 (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	589,069,065	1,328,932,738	1,918,001,803	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		440,106,335		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	BAD DEBT	0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		440,106,335		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0130

Period:
From 09/01/2019
To 08/31/2020

Worksheet G-3

Date/Time Prepared:
3/26/2021 12:42 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,918,001,803	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,560,546,022	2.00
3.00	Net patient revenues (line 1 minus line 2)	357,455,781	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	440,106,335	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-82,650,554	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	176,719	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	1,366,238	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	8,075	21.00
22.00	Rental of hospital space	7,690,722	22.00
23.00	Governmental appropriations	27,364	23.00
24.00	NET ASSETS AND HAP REVENUE	15,109,666	24.00
24.01	OTHER INCOME	7,837,397	24.01
24.50	COVID-19 PHE Funding	27,910,868	24.50
25.00	Total other income (sum of lines 6-24)	60,127,049	25.00
26.00	Total (line 5 plus line 25)	-22,523,505	26.00
27.00	OTHER	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)	-22,523,505	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0130	Period: From 09/01/2019 To 08/31/2020	Worksheet L Parts I-III Date/Time Prepared: 3/26/2021 12:42 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		2,452,638	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		215,496	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		91.65	3.00
4.00	Number of interns & residents (see instructions)		24.01	4.00
5.00	Indirect medical education percentage (see instructions)		7.67	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		188,117	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		2.23	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		17.83	8.00
9.00	Sum of lines 7 and 8		20.06	9.00
10.00	Allowable disproportionate share percentage (see instructions)		4.14	10.00
11.00	Disproportionate share adjustment (see instructions)		101,539	11.00
12.00	Total prospective capital payments (see instructions)		2,957,790	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00