

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050 EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-3027	Period: From 09/01/2019 To 08/31/2020	Worksheet S Parts I-III Date/Time Prepared: 3/26/2021 11:01 am
--	-----------------------	---	---

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 3/26/2021	Time: 11:01 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MARIANJOY REHAB HOSPITAL & CLINIC (14-3027) 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	-611,581	628	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	-1	0		0	7.00
200.00	Total	0	-611,582	628	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-3027		Period: From 09/01/2019 To 08/31/2020		Worksheet S-2 Part I Date/Time Prepared: 3/26/2021 11:01 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 26W171 ROOSEVELT ROAD			PO Box:		Date Certified		Payment System (P, T, O, or N)	
2.00	City: WHEATON			State: IL		Zip Code: 60187		County: DUPAGE	
		Component Name		CCN Number	CBSA Number	Provider Type	Payment System (P, T, O, or N)		
							V	XVIII	XIX
							6.00	7.00	8.00
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			MARIANJOY REHAB HOSPITAL & CLINIC	143027	16974	5	01/01/1973	N P P
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF			MARIANJOY REHAB HOSPITAL & CLINIC	146129	16974		12/18/2008	N P N
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						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.					N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N		23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
				1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	0	0	0	0	0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet S-2
Part I
Date/Time Prepared:
3/26/2021 11:01 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
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.	1,536	538	0	0	1,625		25.00
						Urban/Rural S	Date of Geogr	
						1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
						Beginning:	Ending:	
						1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
						Y/N	Y/N	
						1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
						V	XVIII	XIX
						1.00	2.00	3.00
Prospective Payment System (PPS)-Capital								
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
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.					N		60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet S-2
Part I
Date/Time Prepared:
3/26/2021 11:01 am

	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.			0.00	0.00	0.000000	64.00
Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet S-2
Part I
Date/Time Prepared:
3/26/2021 11:01 am

	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
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
			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.	Y				75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	Y	N	0		76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-3027	Period: From 09/01/2019 To 08/31/2020	Worksheet S-2 Part I Date/Time Prepared: 3/26/2021 11:01 am	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	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.		N	N	N
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-3027	Period: From 09/01/2019 To 08/31/2020	Worksheet S-2 Part I Date/Time Prepared: 3/26/2021 11:01 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:	80,651	120,388	769,007118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	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: 14-3027		Period: From 09/01/2019 To 08/31/2020		Worksheet S-2 Part I Date/Time Prepared: 3/26/2021 11:01 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		Contractor's Name: NGS		Contractor's Number: 00450				141.00	
142.00	Street: 251 E HURON STREET		PO Box:						142.00	
143.00	City: CHICAGO		State: IL		Zip Code: 60611				143.00	
								1.00		
144.00	Are provider based physicians' costs included in Worksheet A?								Y	144.00
								1.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				Y		N		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N				146.00	
								1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital			N	N	N	N		155.00	
156.00	Subprovider - IPF			N	N	N	N		156.00	
157.00	Subprovider - IRF			N	N	N	N		157.00	
158.00	SUBPROVIDER								158.00	
159.00	SNF			N	N	N	N		159.00	
160.00	HOME HEALTH AGENCY			N	N	N	N		160.00	
161.00	CMHC				N	N	N		161.00	
								1.00		
Multicampus										
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00
				Name	County	State	Zip Code	CBSA	FTE/Campus	
				0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00	
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)									168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								0.00	169.00
						Beginning	Ending			
						1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00	
						1.00	2.00			
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N		0	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-3027	Period: From 09/01/2019 To 08/31/2020	Worksheet S-2 Part II Date/Time Prepared: 3/26/2021 11:01 am
			Y/N	Date
			1.00	2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y		5.00
			Y/N	Legal Oper.
			1.00	2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N	
			1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		Y	15.00
		Part A		Part B
		Y/N	Date	Y/N
		1.00	2.00	3.00
		4.00		
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		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	12/16/2020	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: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet S-2
Part II
Date/Time Prepared:
3/26/2021 11:01 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.	BRANDON	HOFMANN		41.00
42.00	Enter the employer/company name of the cost report preparer.	NORTHWESTERN MEMORIAL HEALTHCARE			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	815-766-7529	BRANDON.HOMFANN@NM.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-3027	Period: From 09/01/2019 To 08/31/2020	Worksheet S-2 Part II Date/Time Prepared: 3/26/2021 11:01 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.	SENIOR FINANCIAL ANALYST		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet S-3
Part I
Date/Time Prepared:
3/26/2021 11:01 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	125	43,098	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)		125	43,098	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		125	43,098	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	3,094		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		125			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet S-3
Part I
Date/Time Prepared:
3/26/2021 11:01 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	18,999	2,074	37,665			1.00
2.00	HMO and other (see instructions)	4,615	1,625				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	18,999	2,074	37,665			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	18,999	2,074	37,665	19.00	506.90	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	1,707	0	2,546	0.00	16.53	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				19.00	523.43	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet S-3
Part I
Date/Time Prepared:
3/26/2021 11:01 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	1,355	130	2,532	1.00
2.00 HMO and other (see instructions)			302	111		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,355	130	2,532	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-3027

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

Worksheet A

Date/Time Prepared:
3/26/2021 11:01 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		4,120,461	4,120,461	-873,061	3,247,400	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	873,061	873,061	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	669,044	85,193	754,237	10,422,437	11,176,674	4.00
5.01	00590	A&G NON INTERN & NON RESIDENT	2,494,736	5,056,289	7,551,025	-1,130,573	6,420,452	5.01
5.02	00560	A&G PURCHASING & RECEIVING	183,211	109,739	292,950	-42,644	250,306	5.02
5.03	00570	A&G ADMITTING	1,570,692	418,570	1,989,262	-399,230	1,590,032	5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE	0	0	0	0	0	5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED	2,880,853	18,559,436	21,440,289	-629,251	20,811,038	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	4,808,311	4,808,311	-726,609	4,081,702	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	935,792	901,815	1,837,607	-427,086	1,410,521	9.00
10.00	01000	DIETARY	1,394,137	1,815,833	3,209,970	-1,533,199	1,676,771	10.00
11.00	01100	CAFETERIA	0	0	0	959,474	959,474	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	551,893	147,961	699,854	-107,978	591,876	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	368,903	246,175	615,078	-137,653	477,425	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	377,415	377,415	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	19,396	8,049	27,445	-7,999	19,446	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,379,993	786,295	2,166,288	-367,468	1,798,820	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,018,555	5,029,949	19,048,504	-3,905,044	15,143,460	30.00
44.00	04400	SKILLED NURSING FACILITY	1,554,150	490,200	2,044,350	-433,019	1,611,331	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	64,950	62,290	127,240	95,205	222,445	54.00
60.00	06000	LABORATORY	0	193,805	193,805	416,180	609,985	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	246,341	96,959	343,300	-75,310	267,990	65.00
66.00	06600	PHYSICAL THERAPY	2,736,163	772,856	3,509,019	-642,373	2,866,646	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,884,608	494,286	2,378,894	-475,127	1,903,767	67.00
68.00	06800	SPEECH PATHOLOGY	1,677,788	398,288	2,076,076	-377,250	1,698,826	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	126,588	126,588	8,693	135,281	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,217,308	967,794	2,185,102	-259,146	1,925,956	73.00
74.00	07400	RENAL DIALYSIS	0	310,205	310,205	0	310,205	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	2,069,196	642,017	2,711,213	-302,710	2,408,503	90.01
90.02	09002	OTHER DAY HOSPITAL	1,070,260	390,126	1,460,386	-263,433	1,196,953	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	38,987,969	47,039,490	86,027,459	36,302	86,063,761	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	76,054	17,046	93,100	-16,783	76,317	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	77,372	78,655	156,027	-19,519	136,508	191.01
200.00		TOTAL (SUM OF LINES 118 through 199)	39,141,395	47,135,191	86,276,586	0	86,276,586	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet A
Date/Time Prepared:
3/26/2021 11:01 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	-539,569	2,707,831	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-45,258	827,803	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,993,082	8,183,592	4.00
5.01	00590	A&G NON INTERN & NON RESIDENT	-2,922,455	3,497,997	5.01
5.02	00560	A&G PURCHASING & RECEIVING	0	250,306	5.02
5.03	00570	A&G ADMITTING	-6,270	1,583,762	5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE	0	0	5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED	-6,936,837	13,874,201	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-710,910	3,370,792	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	8.00
9.00	00900	HOUSEKEEPING	0	1,410,521	9.00
10.00	01000	DIETARY	0	1,676,771	10.00
11.00	01100	CAFETERIA	-540,375	419,099	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	591,876	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-1,601	475,824	14.00
15.00	01500	PHARMACY	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	377,415	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	19,446	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	-499,789	1,299,031	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-78,900	15,064,560	30.00
44.00	04400	SKILLED NURSING FACILITY	0	1,611,331	44.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	-470	221,975	54.00
60.00	06000	LABORATORY	0	609,985	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	267,990	65.00
66.00	06600	PHYSICAL THERAPY	-104,866	2,761,780	66.00
67.00	06700	OCCUPATIONAL THERAPY	-151	1,903,616	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,698,826	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	135,281	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-195	1,925,761	73.00
74.00	07400	RENAL DIALYSIS	0	310,205	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	WHEATON OUTPATIENT	-201,178	2,207,325	90.01
90.02	09002	OTHER DAY HOSPITAL	-35,353	1,161,600	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-15,617,259	70,446,502	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	76,317	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	-208	136,300	191.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-15,617,467	70,659,119	200.00

RECLASSIFICATIONS

Provider CCN: 14-3027

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

Worksheet A-6

Date/Time Prepared:
3/26/2021 11:01 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	510,653	448,821		1.00
	TOTALS		510,653	448,821		
	B - MEDICAL SUPPLIES CHARGED TO PATIENTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	8,693		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
	TOTALS		0	8,693		
	C - PATIENT SCHEDULING					
1.00	ADULTS & PEDIATRICS	30.00	519,493	2,776		1.00
2.00	PHYSICAL THERAPY	66.00	1,635	9		2.00
3.00	OCCUPATIONAL THERAPY	67.00	6	0		3.00
4.00	SPEECH PATHOLOGY	68.00	175	1		4.00
5.00	WHEATON OUTPATIENT	90.01	37,047	198		5.00
6.00	OTHER DAY HOSPITAL	90.02	16,612	89		6.00
	TOTALS		574,968	3,073		
	D - STAFF RECLASS					
1.00	SOCIAL SERVICE	17.00	377,415	0		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
	TOTALS		377,415	0		
	E - CROSS DEPARTMENT RECLASS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	109,408	0		1.00
2.00	LABORATORY	60.00	416,180	0		2.00
	TOTALS		525,588	0		
	F - RENTED SPACE RECLASS					
1.00	A&G NON INTERN & NON RESIDENT	5.01	0	18,488		1.00
2.00	A&G OTHER INTERN & RESIDENT RELATED	5.05	0	216,534		2.00
3.00	OPERATION OF PLANT	7.00	0	320,888		3.00
4.00	HOUSEKEEPING	9.00	0	2,874		4.00
5.00	DIETARY	10.00	0	16,779		5.00
6.00	NURSING ADMINISTRATION	13.00	0	15,525		6.00
7.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	13,268		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	72,958		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6,786		9.00
10.00	PHYSICAL THERAPY	66.00	0	115,918		10.00
11.00	OCCUPATIONAL THERAPY	67.00	0	1,750		11.00
12.00	SPEECH PATHOLOGY	68.00	0	2,499		12.00
13.00	WHEATON OUTPATIENT	90.01	0	243,230		13.00
	TOTALS		0	1,047,497		
	H - BENEFITS RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	10,431,099		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
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
	TOTALS		0	10,431,099		

RECLASSIFICATIONS

Provider CCN: 14-3027

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

Worksheet A-6

Date/Time Prepared:
3/26/2021 11:01 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	I - DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	873,061		1.00
	TOTALS		0	873,061		
500.00	Grand Total: Increases		1,988,624	12,812,244		500.00

RECLASSIFICATIONS

Provider CCN: 14-3027

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

Worksheet A-6

Date/Time Prepared:
3/26/2021 11:01 am

	Decreases					3/26/2021 11:01 am	
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	510,653	448,821	0	1.00	
	TOTALS		510,653	448,821			
	B - MEDICAL SUPPLIES CHARGED TO PATIENTS						
1.00	A&G OTHER INTERN & RESIDENT RELATED	5.05	0	45	0	1.00	
2.00	ADULTS & PEDIATRICS	30.00	0	1,657	0	2.00	
3.00	SKILLED NURSING FACILITY	44.00	0	53	0	3.00	
4.00	RESPIRATORY THERAPY	65.00	0	6,934	0	4.00	
5.00	DRUGS CHARGED TO PATIENTS	73.00	0	4	0	5.00	
	TOTALS		0	8,693			
	C - PATIENT SCHEDULING						
1.00	A&G NON INTERN & NON RESIDENT	5.01	574,968	3,073	0	1.00	
2.00		0.00	0	0	0	2.00	
3.00		0.00	0	0	0	3.00	
4.00		0.00	0	0	0	4.00	
5.00		0.00	0	0	0	5.00	
6.00		0.00	0	0	0	6.00	
	TOTALS		574,968	3,073			
	D - STAFF RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	8,662	0	0	1.00	
2.00	A&G OTHER INTERN & RESIDENT RELATED	5.05	242,098	0	0	2.00	
3.00	SKILLED NURSING FACILITY	44.00	19,547	0	0	3.00	
4.00	WHEATON OUTPATIENT	90.01	81,778	0	0	4.00	
5.00	OTHER DAY HOSPITAL	90.02	25,330	0	0	5.00	
	TOTALS		377,415	0			
	E - CROSS DEPARTMENT RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	525,588	0	0	1.00	
2.00		0.00	0	0	0	2.00	
	TOTALS		525,588	0			
	F - RENTED SPACE RECLASS						
1.00	OPERATION OF PLANT	7.00	0	1,047,497	0	1.00	
2.00		0.00	0	0	0	2.00	
3.00		0.00	0	0	0	3.00	
4.00		0.00	0	0	0	4.00	
5.00		0.00	0	0	0	5.00	
6.00		0.00	0	0	0	6.00	
7.00		0.00	0	0	0	7.00	
8.00		0.00	0	0	0	8.00	
9.00		0.00	0	0	0	9.00	
10.00		0.00	0	0	0	10.00	
11.00		0.00	0	0	0	11.00	
12.00		0.00	0	0	0	12.00	
13.00		0.00	0	0	0	13.00	
	TOTALS		0	1,047,497			
	H - BENEFITS RECLASS						
1.00	A&G NON INTERN & NON RESIDENT	5.01	0	571,020	0	1.00	
2.00	A&G PURCHASING & RECEIVING	5.02	0	42,644	0	2.00	
3.00	A&G ADMITTING	5.03	0	399,230	0	3.00	
4.00	A&G OTHER INTERN & RESIDENT RELATED	5.05	0	603,642	0	4.00	
5.00	HOUSEKEEPING	9.00	0	429,960	0	5.00	
6.00	DIETARY	10.00	0	590,504	0	6.00	
7.00	NURSING ADMINISTRATION	13.00	0	123,503	0	7.00	
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	137,653	0	8.00	
9.00	OTHER GENERAL SERVICE (SPECIFY)	18.00	0	7,999	0	9.00	
10.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	380,736	0	10.00	
11.00	ADULTS & PEDIATRICS	30.00	0	3,973,026	0	11.00	
12.00	SKILLED NURSING FACILITY	44.00	0	413,419	0	12.00	
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	20,989	0	13.00	
14.00	RESPIRATORY THERAPY	65.00	0	68,376	0	14.00	
15.00	PHYSICAL THERAPY	66.00	0	759,935	0	15.00	
16.00	OCCUPATIONAL THERAPY	67.00	0	476,883	0	16.00	
17.00	SPEECH PATHOLOGY	68.00	0	379,925	0	17.00	
18.00	DRUGS CHARGED TO PATIENTS	73.00	0	259,142	0	18.00	
19.00	WHEATON OUTPATIENT	90.01	0	501,407	0	19.00	
20.00	OTHER DAY HOSPITAL	90.02	0	254,804	0	20.00	
21.00	RESEARCH	191.00	0	16,783	0	21.00	

RECLASSIFICATIONS

Provider CCN: 14-3027

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

Worksheet A-6

Date/Time Prepared:
3/26/2021 11:01 am

Decreases						wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00	10.00		
22.00	CONTRACT MNGMT & JOINT VENTURE	191.01	0	19,519	0		22.00
	TOTALS		0	10,431,099			
I - DEPRECIATION							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	873,061	9		1.00
	TOTALS		0	873,061			
500.00	Grand Total: Decreases		1,988,624	12,812,244			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet A-7
Part I
Date/Time Prepared:
3/26/2021 11:01 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	6,800,000	0	0	0	0	1.00	
2.00	Land Improvements	0	0	0	0	0	2.00	
3.00	Buildings and Fixtures	67,032,855	4,716,755	0	4,716,755	45,988	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	6,959,017	1,173,053	0	1,173,053	96,851	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	80,791,872	5,889,808	0	5,889,808	142,839	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	80,791,872	5,889,808	0	5,889,808	142,839	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	6,800,000	0				1.00	
2.00	Land Improvements	0	0				2.00	
3.00	Buildings and Fixtures	71,703,622	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	8,035,219	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	86,538,841	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	86,538,841	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet A-7
Part II
Date/Time Prepared:
3/26/2021 11:01 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	4,120,461	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,120,461	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	4,120,461				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	4,120,461				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet A-7
Part III
Date/Time Prepared:
3/26/2021 11:01 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	71,703,622	0	71,703,622	0.899231	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8,035,219	0	8,035,219	0.100769	0	2.00
3.00	Total (sum of lines 1-2)	79,738,841	0	79,738,841	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,707,831	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	827,803	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,535,634	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	2,707,831	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	827,803	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	3,535,634	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-3027

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

Worksheet A-8

Date/Time Prepared:
3/26/2021 11:01 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	
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	-303,726			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	-9,789,086			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-540,375	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	0	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-3027

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

Worksheet A-8

Date/Time Prepared:
3/26/2021 11:01 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	
33.00	OTHER OPERATING REVENUE	B	-950	A&G NON INTERN & NON RESIDENT	5.01	0	33.00
33.01	OTHER OPERATING REVENUE	B	-2,600	A&G ADMITTING	5.03	0	33.01
33.02	OTHER OPERATING REVENUE	B	-23,031	A&G OTHER INTERN & RESIDENT RELATED	5.05	0	33.02
33.03	OTHER OPERATING REVENUE	B	-710,910	OPERATION OF PLANT	7.00	0	33.03
33.04	OTHER OPERATING REVENUE	B	-264,549	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	33.04
33.05	OTHER OPERATING REVENUE	B	-5,502	ADULTS & PEDIATRICS	30.00	0	33.05
33.06	OTHER OPERATING REVENUE	B	-470	RADIOLOGY-DIAGNOSTIC	54.00	0	33.06
33.07	OTHER OPERATING REVENUE	B	-104,673	PHYSICAL THERAPY	66.00	0	33.07
33.08	OTHER OPERATING REVENUE	B	-201,023	WHEATON OUTPATIENT	90.01	0	33.08
34.00	OTHER OPERATING REVENUE	B	-1,650	OTHER DAY HOSPITAL	90.02	0	34.00
34.01	IDPA ASSESSMENTS	A	-2,770,468	A&G NON INTERN & NON RESIDENT	5.01	0	34.01
34.02	TRANSPORTATION EXPENSE	A	-139,376	A&G NON INTERN & NON RESIDENT	5.01	0	34.02
34.03	FUNDRAISING	A	350	A&G NON INTERN & NON RESIDENT	5.01	0	34.03
34.04	LOBBYING	A	-9,987	A&G NON INTERN & NON RESIDENT	5.01	0	34.04
34.05	DISPOSAL WRITE OFF	A	-44	CAP REL COSTS-BLDG & FIXT	1.00	9	34.05
34.06	DISPOSAL WRITE OFF	A	-2,371	ADULTS & PEDIATRICS	30.00	0	34.06
34.07	DISPOSAL WRITE OFF	A	-33,703	OTHER DAY HOSPITAL	90.02	0	34.07
34.08	REAL ESTATE TAXES	A	-4,563	A&G OTHER INTERN & RESIDENT RELATED	5.05	0	34.08
34.09	SCHOLARSHIPS	A	-105,553	A&G OTHER INTERN & RESIDENT RELATED	5.05	0	34.09
34.10	SALES TAX EXPENSES	A	-14	CENTRAL SERVICES & SUPPLY	14.00	0	34.10
34.11	MISC EXPENSE	A	-116	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.11
34.12	MISC EXPENSE	A	-2,024	A&G NON INTERN & NON RESIDENT	5.01	0	34.12
34.13	MISC EXPENSE	A	6,213	A&G OTHER INTERN & RESIDENT RELATED	5.05	0	34.13
34.14	MISC EXPENSE	A	-1,587	CENTRAL SERVICES & SUPPLY	14.00	0	34.14
34.15	MISC EXPENSE	A	-812	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	34.15
34.16	MISC EXPENSE	A	-558	ADULTS & PEDIATRICS	30.00	0	34.16
34.17	MISC EXPENSE	A	-193	PHYSICAL THERAPY	66.00	0	34.17
34.18	MISC EXPENSE	A	-151	OCCUPATIONAL THERAPY	67.00	0	34.18
34.19	MISC EXPENSE	A	-195	DRUGS CHARGED TO PATIENTS	73.00	0	34.19
34.20	MISC EXPENSE	A	-208	CONTRACT MNGMT & JOINT VENTURE	191.01	0	34.20
34.21	MARKETING	A	-3,670	A&G ADMITTING	5.03	0	34.21
34.22	MARKETING	A	-13,783	A&G OTHER INTERN & RESIDENT RELATED	5.05	0	34.22
34.23	MARKETING	A	-1,144	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	34.23
34.24	MARKETING	A	-27	ADULTS & PEDIATRICS	30.00	0	34.24
34.25	MARKETING	A	-155	WHEATON OUTPATIENT	90.01	0	34.25
35.00	MEDICARE DEPRECIATION	A	-539,525	CAP REL COSTS-BLDG & FIXT	1.00	9	35.00
36.00	MEDICARE DEPRECIATION	A	-45,258	CAP REL COSTS-MVBLE EQUIP	2.00	9	36.00
37.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	37.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-15,617,467				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-3027

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

Worksheet A-8-1

Date/Time Prepared:
3/26/2021 11:01 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		4.00	EMPLOYEE BENEFITS DEPARTMENT	NMHC HOME OFFICE	4,726,783	7,719,749 1.00
2.00		5.05	A&G OTHER INTERN & RESIDENT	NMHC HOME OFFICE	10,106,021	16,899,341 2.00
3.00		5.01	A&G NON INTERN & NON RESIDENT	INSURANCE	774,181	774,181 3.00
4.00		5.05	A&G OTHER INTERN & RESIDENT	PURCHASED SERVICE	0	2,800 4.00
4.01		21.00	I&R SERVICES-SALARY & FRINGE	PHYSICIAN SERVICES	292,750	292,750 4.01
4.02		30.00	ADULTS & PEDIATRICS	PHYSICIAN SERVICES	218,702	218,702 4.02
4.03		60.00	LABORATORY	CORPORATE EXPENSE	180,535	180,535 4.03
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				16,298,972	26,088,058 5.00

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

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office		
	1.00	2.00	3.00	Name	Percentage of Ownership	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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

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

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

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

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

Provider CCN: 14-3027

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

Worksheet A-8-1

Date/Time Prepared:
3/26/2021 11:01 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	-2,992,966	0		1.00
2.00	-6,793,320	0		2.00
3.00	0	0		3.00
4.00	-2,800	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
5.00	-9,789,086			5.00

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

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

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

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

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

6.00	MOTHER HOUSE		6.00
7.00	CORPORATE OFFIC		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-3027

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

Worksheet A-8-2

Date/Time Prepared:
3/26/2021 11:01 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	21.00	I&R SERVICES-SALARY & FRINGES APPRV	190,000	0	190,000	179,000	691	1.00
2.00	21.00	I&R SERVICES-SALARY & FRINGES APPRV	102,750	102,750	0	179,000	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	138,600	0	138,600	179,000	792	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			431,350	102,750	328,600		1,483	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	21.00	I&R SERVICES-SALARY & FRINGES APPRV	59,466	2,973	0	0	0	1.00
2.00	21.00	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	68,158	3,408	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			127,624	6,381	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	21.00	I&R SERVICES-SALARY & FRINGES APPRV	0	59,466	130,534	130,534		1.00
2.00	21.00	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	102,750		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	68,158	70,442	70,442		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	127,624	200,976	303,726		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet B
Part I
Date/Time Prepared:
3/26/2021 11:01 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	A&G NON INTERN & NON RESIDENT	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	5.01
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,707,831	2,707,831			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	827,803		827,803		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,183,592	0	0	8,183,592	4.00
5.01	00590	A&G NON INTERN & NON RESIDENT	3,497,997	16,390	53,665	408,269	3,976,321
5.02	00560	A&G PURCHASING & RECEIVING	250,306	0	17,025	38,963	0
5.03	00570	A&G ADMITTING	1,583,762	28,966	3,532	334,033	0
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE	0	0	0	0	0
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED	13,874,201	0	54,891	561,173	0
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00	00700	OPERATION OF PLANT	3,370,792	736,296	142,275	0	0
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0
9.00	00900	HOUSEKEEPING	1,410,521	19,119	67,951	199,011	0
10.00	01000	DIETARY	1,676,771	92,603	23,434	187,887	0
11.00	01100	CAFETERIA	419,099	0	0	108,599	0
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	591,876	0	0	117,369	0
14.00	01400	CENTRAL SERVICES & SUPPLY	475,824	0	0	78,453	0
15.00	01500	PHARMACY	0	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0
17.00	01700	SOCIAL SERVICE	377,415	0	0	80,263	0
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	19,446	0	0	4,125	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,299,031	6,047	0	293,478	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	15,064,560	1,532,384	168,348	2,979,963	1,830,415
44.00	04400	SKILLED NURSING FACILITY	1,611,331	101,752	0	326,358	60,710
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	221,975	0	28,912	37,080	57,125
60.00	06000	LABORATORY	609,985	1,907	0	88,507	179,309
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	267,990	0	1,531	52,388	47,481
66.00	06600	PHYSICAL THERAPY	2,761,780	67,824	17,006	582,237	530,739
67.00	06700	OCCUPATIONAL THERAPY	1,903,616	0	1,640	400,793	499,194
68.00	06800	SPEECH PATHOLOGY	1,698,826	0	25,972	356,846	372,317
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	135,281	35,897	0	0	28,982
73.00	07300	DRUGS CHARGED TO PATIENTS	1,925,761	24,469	63,723	258,880	346,059
74.00	07400	RENAL DIALYSIS	310,205	0	0	0	23,171
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	WHEATON OUTPATIENT	2,207,325	0	31,881	430,535	653
90.02	09002	OTHER DAY HOSPITAL	1,161,600	0	27,327	225,754	166
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	70,446,502	2,663,654	729,113	8,150,964	3,976,321
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00	19100	RESEARCH	76,317	44,177	96,567	16,174	0
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	136,300	0	2,123	16,454	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	70,659,119	2,707,831	827,803	8,183,592	3,976,321

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet B
Part I
Date/Time Prepared:
3/26/2021 11:01 am

Cost Center Description			A&G PURCHASING & RECEIVING	A&G ADMITTING	A&G PFS CASHIER/ACCTS RECEIVABLE	Subtotal	A&G OTHER INTERN & RESIDENT RELATED	
			5.02	5.03	5.04	5A.04	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	A&G NON INTERN & NON RESIDENT						5.01
5.02	00560	A&G PURCHASING & RECEIVING	306,294					5.02
5.03	00570	A&G ADMITTING	27	1,950,320				5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE	0	0	0			5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED	21,801	0	0	14,512,066	14,512,066	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	181	0	0	4,249,544	1,098,358	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	4	0	0	1,696,606	438,513	9.00
10.00	01000	DIETARY	0	0	0	1,980,695	511,940	10.00
11.00	01100	CAFETERIA	0	0	0	527,698	136,391	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	179	0	0	709,424	183,361	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,016	0	0	561,293	145,075	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	457,678	118,294	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	23,571	6,092	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	2	0	0	1,598,558	413,171	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	111,122	810,896	0	22,497,688	5,814,885	30.00
44.00	04400	SKILLED NURSING FACILITY	11,134	26,897	0	2,138,182	552,645	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	85	25,309	0	370,486	95,758	54.00
60.00	06000	LABORATORY	2,573	79,443	0	961,724	248,572	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	4,184	21,036	0	394,610	101,993	65.00
66.00	06600	PHYSICAL THERAPY	834	240,701	0	4,201,121	1,085,843	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,016	221,186	0	3,028,445	782,747	67.00
68.00	06800	SPEECH PATHOLOGY	1,244	165,550	0	2,620,755	677,373	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,194	12,840	0	218,194	56,396	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	132,691	153,321	0	2,904,904	750,816	73.00
74.00	07400	RENAL DIALYSIS	0	10,266	0	343,642	88,819	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	5,148	126,328	0	2,801,870	724,185	90.01
90.02	09002	OTHER DAY HOSPITAL	859	56,547	0	1,472,253	380,526	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	306,294	1,950,320	0	70,271,007	14,411,753	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	233,235	60,283	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	0	0	154,877	40,030	191.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	306,294	1,950,320	0	70,659,119	14,512,066	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet B
Part I
Date/Time Prepared:
3/26/2021 11:01 am

Cost Center Description			MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	A&G NON INTERN & NON RESIDENT						5.01
5.02	00560	A&G PURCHASING & RECEIVING						5.02
5.03	00570	A&G ADMITTING						5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE						5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED						5.05
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	5,347,902				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0			8.00
9.00	00900	HOUSEKEEPING	0	53,083	0	2,188,202		9.00
10.00	01000	DIETARY	0	257,106	0	106,255	2,855,996	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	16,790	0	6,939	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	4,254,557	0	1,758,290	2,675,166	30.00
44.00	04400	SKILLED NURSING FACILITY	0	282,506	0	116,752	180,830	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	5,295	0	2,188	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	188,309	0	77,823	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	99,665	0	41,189	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	67,936	0	28,076	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5,225,247	0	2,137,512	2,855,996	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	122,655	0	50,690	0	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	0	0	0	0	191.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	5,347,902	0	2,188,202	2,855,996	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet B
Part I
Date/Time Prepared:
3/26/2021 11:01 am

Cost Center Description			CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	A&G NON INTERN & NON RESIDENT						5.01
5.02	00560	A&G PURCHASING & RECEIVING						5.02
5.03	00570	A&G ADMITTING						5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE						5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	664,089					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	10,022	0	902,807			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,904	0	0	719,272		14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	7,678	0	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	736	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	32,618	0	0	4	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	348,246	0	902,807	288,456	0	30.00
44.00	04400	SKILLED NURSING FACILITY	34,396	0	0	28,903	0	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,688	0	0	219	0	54.00
60.00	06000	LABORATORY	10,568	0	0	6,678	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	5,964	0	0	10,860	0	65.00
66.00	06600	PHYSICAL THERAPY	64,843	0	0	2,165	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	39,493	0	0	5,234	0	67.00
68.00	06800	SPEECH PATHOLOGY	29,523	0	0	3,230	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	13,484	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	344,446	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	39,457	0	0	13,364	0	90.01
90.02	09002	OTHER DAY HOSPITAL	20,137	0	0	2,229	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	661,273	0	902,807	719,272	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	1,381	0	0	0	0	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	1,435	0	0	0	0	191.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	664,089	0	902,807	719,272	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet B
Part I
Date/Time Prepared:
3/26/2021 11:01 am

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			16.00	17.00	18.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	A&G NON INTERN & NON RESIDENT						5.01
5.02	00560	A&G PURCHASING & RECEIVING						5.02
5.03	00570	A&G ADMITTING						5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE						5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0					16.00
17.00	01700	SOCIAL SERVICE	0	583,650				17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	30,399			18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	583,650	30,399	0	0	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	583,650	30,399	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	0	0	0	0	191.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	583,650	30,399	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet B
Part I
Date/Time Prepared:
3/26/2021 11:01 am

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	A&G NON INTERN & NON RESIDENT						5.01
5.02	00560	A&G PURCHASING & RECEIVING						5.02
5.03	00570	A&G ADMITTING						5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE						5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)						18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	2,068,080					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,068,080	0	0	41,222,224	-2,068,080	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	3,334,214	0	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	471,151	0	54.00
60.00	06000	LABORATORY	0	0	0	1,235,025	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	513,427	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,620,104	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,855,919	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,330,881	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	428,928	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,096,178	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	432,461	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	0	0	0	3,578,876	0	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	0	1,875,145	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,068,080	0	0	69,994,533	-2,068,080	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	468,244	0	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	0	0	196,342	0	191.01
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,068,080	0	0	70,659,119	-2,068,080	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet B
Part I
Date/Time Prepared:
3/26/2021 11:01 am

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00590	A&G NON INTERN & NON RESIDENT	5.01
5.02	00560	A&G PURCHASING & RECEIVING	5.02
5.03	00570	A&G ADMITTING	5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE	5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED	5.05
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
44.00	04400	SKILLED NURSING FACILITY	44.00
ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
90.01	09001	WHEATON OUTPATIENT	90.01
90.02	09002	OTHER DAY HOSPITAL	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
191.00	19100	RESEARCH	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	191.01
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet B
Part II
Date/Time Prepared:
3/26/2021 11:01 am

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.01	00590	A&G NON INTERN & NON RESIDENT	417	16,390	53,665	70,472	0 5.01
5.02	00560	A&G PURCHASING & RECEIVING	11,064	0	17,025	28,089	0 5.02
5.03	00570	A&G ADMITTING	159	28,966	3,532	32,657	0 5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE	0	0	0	0	0 5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED	1,402,011	0	54,891	1,456,902	0 5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0 6.00
7.00	00700	OPERATION OF PLANT	1,047,495	736,296	142,275	1,926,066	0 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0 8.00
9.00	00900	HOUSEKEEPING	5,857	19,119	67,951	92,927	0 9.00
10.00	01000	DIETARY	15,328	92,603	23,434	131,365	0 10.00
11.00	01100	CAFETERIA	0	0	0	0	0 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,087	0	0	2,087	0 14.00
15.00	01500	PHARMACY	0	0	0	0	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0 17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0 18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0 20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	2,723	6,047	0	8,770	0 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0 22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	13,091	1,532,384	168,348	1,713,823	0 30.00
44.00	04400	SKILLED NURSING FACILITY	1,048	101,752	0	102,800	0 44.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	28,912	28,912	0 54.00
60.00	06000	LABORATORY	0	1,907	0	1,907	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0	0	1,531	1,531	0 65.00
66.00	06600	PHYSICAL THERAPY	206	67,824	17,006	85,036	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	1,640	1,640	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	25,972	25,972	0 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	96,583	35,897	0	132,480	0 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	969	24,469	63,723	89,161	0 73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0 74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	WHEATON OUTPATIENT	3,821	0	31,881	35,702	0 90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	27,327	27,327	0 90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	0 92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,602,859	2,663,654	729,113	5,995,626	0 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
191.00	19100	RESEARCH	153	44,177	96,567	140,897	0 191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	0	2,123	2,123	0 191.01
200.00		Cross Foot Adjustments				0	0 200.00
201.00		Negative Cost Centers				0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	2,603,012	2,707,831	827,803	6,138,646	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet B
Part II
Date/Time Prepared:
3/26/2021 11:01 am

Cost Center Description			A&G NON INTERN & NON RESIDENT	A&G PURCHASING & RECEIVING	A&G ADMITTING	A&G PFS CASHIER/ACCTS RECEIVABLE	A&G OTHER INTERN & RESIDENT RELATED	
			5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	A&G NON INTERN & NON RESIDENT	70,472					5.01
5.02	00560	A&G PURCHASING & RECEIVING	0	28,089				5.02
5.03	00570	A&G ADMITTING	0	2	32,659			5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE	0	0	0	0		5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED	0	1,999	0	0	1,458,901	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	17	0	0	110,420	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	44,085	9.00
10.00	01000	DIETARY	0	0	0	0	51,466	10.00
11.00	01100	CAFETERIA	0	0	0	0	13,712	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	16	0	0	18,434	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	643	0	0	14,585	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	11,892	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	612	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	41,537	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	32,455	10,191	13,573	0	584,555	30.00
44.00	04400	SKILLED NURSING FACILITY	1,076	1,021	451	0	55,559	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,012	8	424	0	9,627	54.00
60.00	06000	LABORATORY	3,177	236	1,331	0	24,989	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	841	384	352	0	10,254	65.00
66.00	06600	PHYSICAL THERAPY	9,402	76	4,032	0	109,162	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,844	185	3,705	0	78,691	67.00
68.00	06800	SPEECH PATHOLOGY	6,596	114	2,773	0	68,098	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	513	476	215	0	5,670	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,131	12,170	2,568	0	75,481	73.00
74.00	07400	RENAL DIALYSIS	410	0	172	0	8,929	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	12	472	2,116	0	72,804	90.01
90.02	09002	OTHER DAY HOSPITAL	3	79	947	0	38,255	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	70,472	28,089	32,659	0	1,448,817	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	6,060	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	0	0	0	4,024	191.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	70,472	28,089	32,659	0	1,458,901	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet B
Part II
Date/Time Prepared:
3/26/2021 11:01 am

Cost Center Description			MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	A&G NON INTERN & NON RESIDENT						5.01
5.02	00560	A&G PURCHASING & RECEIVING						5.02
5.03	00570	A&G ADMITTING						5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE						5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED						5.05
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	2,036,503				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0			8.00
9.00	00900	HOUSEKEEPING	0	20,214	0	157,226		9.00
10.00	01000	DIETARY	0	97,907	0	7,635	288,373	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	6,394	0	499	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	1,620,152	0	126,336	270,114	30.00
44.00	04400	SKILLED NURSING FACILITY	0	107,580	0	8,389	18,259	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	2,017	0	157	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	71,709	0	5,592	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	37,953	0	2,959	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	25,870	0	2,017	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,989,796	0	153,584	288,373	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	46,707	0	3,642	0	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	0	0	0	0	191.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,036,503	0	157,226	288,373	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet B
Part II
Date/Time Prepared:
3/26/2021 11:01 am

Cost Center Description			CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	A&G NON INTERN & NON RESIDENT						5.01
5.02	00560	A&G PURCHASING & RECEIVING						5.02
5.03	00570	A&G ADMITTING						5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE						5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	13,712					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	207	0	18,657			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	266	0	0	17,581		14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	159	0	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	15	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	673	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,190	0	18,657	7,051	0	30.00
44.00	04400	SKILLED NURSING FACILITY	710	0	0	706	0	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	97	0	0	5	0	54.00
60.00	06000	LABORATORY	218	0	0	163	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	123	0	0	265	0	65.00
66.00	06600	PHYSICAL THERAPY	1,339	0	0	53	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	815	0	0	128	0	67.00
68.00	06800	SPEECH PATHOLOGY	610	0	0	79	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	330	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,420	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	815	0	0	327	0	90.01
90.02	09002	OTHER DAY HOSPITAL	416	0	0	54	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,653	0	18,657	17,581	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	29	0	0	0	0	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	30	0	0	0	0	191.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	13,712	0	18,657	17,581	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet B
Part II
Date/Time Prepared:
3/26/2021 11:01 am

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			16.00	17.00	18.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	A&G NON INTERN & NON RESIDENT						5.01
5.02	00560	A&G PURCHASING & RECEIVING						5.02
5.03	00570	A&G ADMITTING						5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE						5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0					16.00
17.00	01700	SOCIAL SERVICE	0	12,051				17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	627			18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	12,051	627			30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0			44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0			54.00
60.00	06000	LABORATORY	0	0	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0			65.00
66.00	06600	PHYSICAL THERAPY	0	0	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0			68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0			71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0			73.00
74.00	07400	RENAL DIALYSIS	0	0	0			74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	0	0	0			90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	0			90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	12,051	627	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190.00
191.00	19100	RESEARCH	0	0	0			191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	0	0			191.01
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	12,051	627	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet B
Part II
Date/Time Prepared:
3/26/2021 11:01 am

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	A&G NON INTERN & NON RESIDENT						5.01
5.02	00560	A&G PURCHASING & RECEIVING						5.02
5.03	00570	A&G ADMITTING						5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE						5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)						18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	57,873					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				4,416,775	0	30.00
44.00	04400	SKILLED NURSING FACILITY				296,551	0	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC				40,085	0	54.00
60.00	06000	LABORATORY				34,195	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
65.00	06500	RESPIRATORY THERAPY				13,750	0	65.00
66.00	06600	PHYSICAL THERAPY				286,401	0	66.00
67.00	06700	OCCUPATIONAL THERAPY				94,008	0	67.00
68.00	06800	SPEECH PATHOLOGY				104,242	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				180,596	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS				221,818	0	73.00
74.00	07400	RENAL DIALYSIS				9,511	0	74.00
76.97	07697	CARDIAC REHABILITATION				0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				0	0	76.98
76.99	07699	LITHOTRIPSY				0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT				112,248	0	90.01
90.02	09002	OTHER DAY HOSPITAL				67,081	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	5,877,261	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				0	0	190.00
191.00	19100	RESEARCH				197,335	0	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE				6,177	0	191.01
200.00		Cross Foot Adjustments	57,873	0	0	57,873	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	57,873	0	0	6,138,646	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet B
Part II
Date/Time Prepared:
3/26/2021 11:01 am

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00590	A&G NON INTERN & NON RESIDENT	5.01
5.02	00560	A&G PURCHASING & RECEIVING	5.02
5.03	00570	A&G ADMITTING	5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE	5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED	5.05
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
44.00	04400	SKILLED NURSING FACILITY	44.00
ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
90.01	09001	WHEATON OUTPATIENT	90.01
90.02	09002	OTHER DAY HOSPITAL	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
191.00	19100	RESEARCH	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	191.01
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-3027

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

Worksheet B-1

Date/Time Prepared:
3/26/2021 11:01 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	A&G NON INTERN & NON RESIDENT (INPATIENT REVENUE)	A&G PURCHASING & RECEIVING (ALLOCATION 1)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	174,629					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		820,137				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	38,481,013			4.00
5.01	00590	A&G NON INTERN & NON RESIDENT	1,057	53,168	1,919,768	125,565,974		5.01
5.02	00560	A&G PURCHASING & RECEIVING	0	16,867	183,211	0	1,558,455	5.02
5.03	00570	A&G ADMITTING	1,868	3,499	1,570,692	0	136	5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE	0	0	0	0	0	5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED	0	54,383	2,638,755	0	110,925	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	47,484	140,957	0	0	919	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,233	67,322	935,792	0	21	9.00
10.00	01000	DIETARY	5,972	23,217	883,484	0	0	10.00
11.00	01100	CAFETERIA	0	0	510,653	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	551,893	0	909	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	368,903	0	35,699	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	377,415	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	19,396	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	390	0	1,379,993	0	8	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	98,824	166,789	14,012,460	57,801,257	565,402	30.00
44.00	04400	SKILLED NURSING FACILITY	6,562	0	1,534,603	1,917,126	56,653	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	28,644	174,358	1,803,924	430	54.00
60.00	06000	LABORATORY	123	0	416,180	5,662,338	13,090	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,517	246,341	1,499,372	21,287	65.00
66.00	06600	PHYSICAL THERAPY	4,374	16,849	2,737,798	16,760,008	4,243	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,625	1,884,614	15,763,840	10,259	67.00
68.00	06800	SPEECH PATHOLOGY	0	25,731	1,677,963	11,757,258	6,332	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,315	0	0	915,212	26,430	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,578	63,133	1,217,308	10,928,062	675,148	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	731,712	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	0	31,586	2,024,465	20,624	26,194	90.01
90.02	09002	OTHER DAY HOSPITAL	0	27,074	1,061,542	5,241	4,370	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	171,780	722,361	38,327,587	125,565,974	1,558,455	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	2,849	95,673	76,054	0	0	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	2,103	77,372	0	0	191.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,707,831	827,803	8,183,592	3,976,321	306,294	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.506193	1.009347	0.212666	0.031667	0.196537	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	70,472	28,089	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	0.000561	0.018024	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-3027

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

Worksheet B-1

Date/Time Prepared:
3/26/2021 11:01 am

Cost Center Description			A&G ADMITTING (GROSS REVENUE)	A&G PFS CASHIER/ACCTS RECEIVABLE (INPATIENT REVENUE)	Reconciliation	A&G OTHER INTERN & RESIDENT RELATED (ACCUM COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
			5.03	5.04	5A.05	5.05	6.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	A&G NON INTERN & NON RESIDENT						5.01
5.02	00560	A&G PURCHASING & RECEIVING						5.02
5.03	00570	A&G ADMITTING	139,014,712					5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE	0	125,565,974				5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED	0	0	-14,512,066	56,147,053		5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	171,704	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	4,249,544	47,484	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	1,696,606	1,233	9.00
10.00	01000	DIETARY	0	0	0	1,980,695	5,972	10.00
11.00	01100	CAFETERIA	0	0	0	527,698	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	709,424	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	561,293	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	457,678	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	23,571	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	1,598,558	390	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	57,801,257	57,801,257	0	22,497,688	98,824	30.00
44.00	04400	SKILLED NURSING FACILITY	1,917,126	1,917,126	0	2,138,182	6,562	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,803,924	1,803,924	0	370,486	0	54.00
60.00	06000	LABORATORY	5,662,338	5,662,338	0	961,724	123	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,499,372	1,499,372	0	394,610	0	65.00
66.00	06600	PHYSICAL THERAPY	17,156,195	16,760,008	0	4,201,121	4,374	66.00
67.00	06700	OCCUPATIONAL THERAPY	15,765,240	15,763,840	0	3,028,445	0	67.00
68.00	06800	SPEECH PATHOLOGY	11,799,711	11,757,258	0	2,620,755	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	915,212	915,212	0	218,194	2,315	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,928,062	10,928,062	0	2,904,904	1,578	73.00
74.00	07400	RENAL DIALYSIS	731,712	731,712	0	343,642	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	9,004,127	20,624	0	2,801,870	0	90.01
90.02	09002	OTHER DAY HOSPITAL	4,030,436	5,241	0	1,472,253	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	139,014,712	125,565,974	-14,512,066	55,758,941	168,855	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	233,235	2,849	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	0	0	154,877	0	191.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,950,320	0		14,512,066	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.014030	0.000000		0.258465	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	32,659	0		1,458,901	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000235	0.000000		0.025984	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-3027

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

Worksheet B-1

Date/Time Prepared:
3/26/2021 11:01 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	A&G NON INTERN & NON RESIDENT					5.01
5.02	00560	A&G PURCHASING & RECEIVING					5.02
5.03	00570	A&G ADMITTING					5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE					5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED					5.05
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT	124,220				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0			8.00
9.00	00900	HOUSEKEEPING	1,233	0	122,987		9.00
10.00	01000	DIETARY	5,972	0	5,972	40,211	10.00
11.00	01100	CAFETERIA	0	0	0	800,781	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	12,085	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	15,560	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	9,258	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	888	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	390	0	390	39,332	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	98,824	0	98,824	37,665	30.00
44.00	04400	SKILLED NURSING FACILITY	6,562	0	6,562	2,546	44.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	5,653	54.00
60.00	06000	LABORATORY	123	0	123	12,743	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,191	65.00
66.00	06600	PHYSICAL THERAPY	4,374	0	4,374	78,190	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	47,622	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	35,600	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,315	0	2,315	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,578	0	1,578	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	WHEATON OUTPATIENT	0	0	0	47,578	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	0	24,282	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	121,371	0	120,138	40,211	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100	RESEARCH	2,849	0	2,849	1,665	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	0	0	1,730	191.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,347,902	0	2,188,202	2,855,996	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	43.051860	0.000000	17.792141	71.025242	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,036,503	0	157,226	288,373	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	16.394325	0.000000	1.278395	7.171495	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-3027

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

Worksheet B-1

Date/Time Prepared:
3/26/2021 11:01 am

Cost Center Description			MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (ALLOCATION 2)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
			12.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	A&G NON INTERN & NON RESIDENT						5.01
5.02	00560	A&G PURCHASING & RECEIVING						5.02
5.03	00570	A&G ADMITTING						5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE						5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0					12.00
13.00	01300	NURSING ADMINISTRATION	0	1,000				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,409,846			14.00
15.00	01500	PHARMACY	0	0	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	139,014,712	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	8	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	1,000	565,402	0	57,801,257	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	56,653	0	1,917,126	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	430	0	1,803,924	54.00
60.00	06000	LABORATORY	0	0	13,090	0	5,662,338	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	21,287	0	1,499,372	65.00
66.00	06600	PHYSICAL THERAPY	0	0	4,243	0	17,156,195	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	10,259	0	15,765,240	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	6,332	0	11,799,711	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	26,430	0	915,212	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	675,148	0	10,928,062	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	731,712	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	0	0	26,194	0	9,004,127	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	4,370	0	4,030,436	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,000	1,409,846	0	139,014,712	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	0	0	0	0	191.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	902,807	719,272	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	902.807000	0.510178	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	18,657	17,581	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	18.657000	0.012470	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-3027

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

Worksheet B-1

Date/Time Prepared:
3/26/2021 11:01 am

Cost Center Description			SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE (SPECIFY) (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			17.00	18.00	19.00	20.00	21.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	A&G NON INTERN & NON RESIDENT						5.01
5.02	00560	A&G PURCHASING & RECEIVING						5.02
5.03	00570	A&G ADMITTING						5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE						5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	1,000					17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	1,000				18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			1,000	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,000	1,000	0	0	1,000	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,000	1,000	0	0	1,000	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	0	0	0	0	191.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	583,650	30,399	0	0	2,068,080	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	583.650000	30.399000	0.000000	0.000000	2,068.080000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	12,051	627	0	0	57,873	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	12.051000	0.627000	0.000000	0.000000	57.873000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-3027

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

Worksheet B-1

Date/Time Prepared:
3/26/2021 11:01 am

Cost Center Description			INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)	
			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
5.01	00590	A&G NON INTERN & NON RESIDENT			5.01
5.02	00560	A&G PURCHASING & RECEIVING			5.02
5.03	00570	A&G ADMITTING			5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE			5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED			5.05
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)			18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	1,000		22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)		0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,000	0	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	WHEATON OUTPATIENT	0	0	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,000	0	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	0	191.01
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet C
Part I
Date/Time Prepared:
3/26/2021 11:01 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	39,154,144		39,154,144	70,442	39,224,586	30.00	
44.00	04400	SKILLED NURSING FACILITY	3,334,214		3,334,214	0	3,334,214	44.00	
ANCILLARY SERVICE COST CENTERS									
54.00	05400	RADIOLOGY-DIAGNOSTIC	471,151		471,151	0	471,151	54.00	
60.00	06000	LABORATORY	1,235,025		1,235,025	0	1,235,025	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	513,427	0	513,427	0	513,427	65.00	
66.00	06600	PHYSICAL THERAPY	5,620,104	0	5,620,104	0	5,620,104	66.00	
67.00	06700	OCCUPATIONAL THERAPY	3,855,919	0	3,855,919	0	3,855,919	67.00	
68.00	06800	SPEECH PATHOLOGY	3,330,881	0	3,330,881	0	3,330,881	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	428,928		428,928	0	428,928	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	4,096,178		4,096,178	0	4,096,178	73.00	
74.00	07400	RENAL DIALYSIS	432,461		432,461	0	432,461	74.00	
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	WHEATON OUTPATIENT	3,578,876		3,578,876	0	3,578,876	90.01	
90.02	09002	OTHER DAY HOSPITAL	1,875,145		1,875,145	0	1,875,145	90.02	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00	
200.00		Subtotal (see instructions)	67,926,453	0	67,926,453	70,442	67,996,895	200.00	
201.00		Less Observation Beds	0		0		0	201.00	
202.00		Total (see instructions)	67,926,453	0	67,926,453	70,442	67,996,895	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-3027		Period: From 09/01/2019 To 08/31/2020		Worksheet C Part I Date/Time Prepared: 3/26/2021 11:01 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				
				9.00				10.00		
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	57,801,257		57,801,257				30.00	
44.00	04400	SKILLED NURSING FACILITY	1,917,126		1,917,126				44.00	
ANCILLARY SERVICE COST CENTERS										
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,803,924	0	1,803,924	0.261181	0.000000	54.00		
60.00	06000	LABORATORY	5,662,338	0	5,662,338	0.218112	0.000000	60.00		
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30		
65.00	06500	RESPIRATORY THERAPY	1,499,372	0	1,499,372	0.342428	0.000000	65.00		
66.00	06600	PHYSICAL THERAPY	16,760,008	396,187	17,156,195	0.327585	0.000000	66.00		
67.00	06700	OCCUPATIONAL THERAPY	15,763,840	1,400	15,765,240	0.244584	0.000000	67.00		
68.00	06800	SPEECH PATHOLOGY	11,757,258	42,453	11,799,711	0.282285	0.000000	68.00		
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	915,212	0	915,212	0.468665	0.000000	71.00		
73.00	07300	DRUGS CHARGED TO PATIENTS	10,928,062	0	10,928,062	0.374831	0.000000	73.00		
74.00	07400	RENAL DIALYSIS	731,712	0	731,712	0.591026	0.000000	74.00		
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97		
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98		
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99		
OUTPATIENT SERVICE COST CENTERS										
90.01	09001	WHEATON OUTPATIENT	20,624	8,983,503	9,004,127	0.397471	0.000000	90.01		
90.02	09002	OTHER DAY HOSPITAL	5,241	4,025,195	4,030,436	0.465246	0.000000	90.02		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00		
200.00		Subtotal (see instructions)	125,565,974	13,448,738	139,014,712			200.00		
201.00		Less Observation Beds						201.00		
202.00		Total (see instructions)	125,565,974	13,448,738	139,014,712			202.00		

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet C
Part I
Date/Time Prepared:
3/26/2021 11:01 am

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.261181			54.00
60.00	06000	LABORATORY	0.218112			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.342428			65.00
66.00	06600	PHYSICAL THERAPY	0.327585			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.244584			67.00
68.00	06800	SPEECH PATHOLOGY	0.282285			68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.468665			71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.374831			73.00
74.00	07400	RENAL DIALYSIS	0.591026			74.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
90.01	09001	WHEATON OUTPATIENT	0.397471			90.01
90.02	09002	OTHER DAY HOSPITAL	0.465246			90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet C
Part I
Date/Time Prepared:
3/26/2021 11:01 am

				Title XIX		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE		Total Costs	
						Disallowance			
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	41,222,224		41,222,224	70,442	41,292,666	30.00	
44.00	04400	SKILLED NURSING FACILITY	3,334,214		3,334,214	0	3,334,214	44.00	
ANCILLARY SERVICE COST CENTERS									
54.00	05400	RADIOLOGY-DIAGNOSTIC	471,151		471,151	0	471,151	54.00	
60.00	06000	LABORATORY	1,235,025		1,235,025	0	1,235,025	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	513,427	0	513,427	0	513,427	65.00	
66.00	06600	PHYSICAL THERAPY	5,620,104	0	5,620,104	0	5,620,104	66.00	
67.00	06700	OCCUPATIONAL THERAPY	3,855,919	0	3,855,919	0	3,855,919	67.00	
68.00	06800	SPEECH PATHOLOGY	3,330,881	0	3,330,881	0	3,330,881	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	428,928		428,928	0	428,928	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	4,096,178		4,096,178	0	4,096,178	73.00	
74.00	07400	RENAL DIALYSIS	432,461		432,461	0	432,461	74.00	
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	WHEATON OUTPATIENT	3,578,876		3,578,876	0	3,578,876	90.01	
90.02	09002	OTHER DAY HOSPITAL	1,875,145		1,875,145	0	1,875,145	90.02	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00	
200.00		Subtotal (see instructions)	69,994,533	0	69,994,533	70,442	70,064,975	200.00	
201.00		Less Observation Beds	0		0		0	201.00	
202.00		Total (see instructions)	69,994,533	0	69,994,533	70,442	70,064,975	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet C
Part I
Date/Time Prepared:
3/26/2021 11:01 am

			Title XIX			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00				
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0		0			30.00	
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00	
	ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00	
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	0		0	0.000000	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0.000000	0.000000	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0.000000	0.000000	76.98	
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99	
	OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	0	0	0	0.000000	0.000000	90.01	
90.02	09002	OTHER DAY HOSPITAL	0	0	0	0.000000	0.000000	90.02	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00	
200.00		Subtotal (see instructions)	0	0	0			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	0	0	0			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet C
Part I
Date/Time Prepared:
3/26/2021 11:01 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
44.00	04400 SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400 RENAL DIALYSIS	0.000000			74.00
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699 LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	09001 WHEATON OUTPATIENT	0.000000			90.01
90.02	09002 OTHER DAY HOSPITAL	0.000000			90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

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

Provider CCN: 14-3027

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

Worksheet C
Part II
Date/Time Prepared:
3/26/2021 11:01 am

			Title XIX		Hospital	PPS	
Cost Center Description			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount
			1.00	2.00	3.00	4.00	5.00
	ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	471,151	40,085	431,066	0	54.00
60.00	06000	LABORATORY	1,235,025	34,195	1,200,830	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	513,427	13,750	499,677	0	65.00
66.00	06600	PHYSICAL THERAPY	5,620,104	286,401	5,333,703	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,855,919	94,008	3,761,911	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,330,881	104,242	3,226,639	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	428,928	180,596	248,332	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,096,178	221,818	3,874,360	0	73.00
74.00	07400	RENAL DIALYSIS	432,461	9,511	422,950	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	09001	WHEATON OUTPATIENT	3,578,876	112,248	3,466,628	0	90.01
90.02	09002	OTHER DAY HOSPITAL	1,875,145	67,081	1,808,064	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	25,438,095	1,163,935	24,274,160	0	200.00
201.00		Less Observation Beds	0	0	0	0	201.00
202.00		Total (line 200 minus line 201)	25,438,095	1,163,935	24,274,160	0	202.00

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

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet C
Part II
Date/Time Prepared:
3/26/2021 11:01 am

Cost Center Description			Title XIX		Hospital	PPS
			Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	471,151	1,803,924	0.261181	54.00
60.00	06000	LABORATORY	1,235,025	5,662,338	0.218112	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	513,427	1,499,372	0.342428	65.00
66.00	06600	PHYSICAL THERAPY	5,620,104	17,156,195	0.327585	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,855,919	15,765,240	0.244584	67.00
68.00	06800	SPEECH PATHOLOGY	3,330,881	11,799,711	0.282285	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	428,928	915,212	0.468665	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,096,178	10,928,062	0.374831	73.00
74.00	07400	RENAL DIALYSIS	432,461	731,712	0.591026	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS						
90.01	09001	WHEATON OUTPATIENT	3,578,876	9,004,127	0.397471	90.01
90.02	09002	OTHER DAY HOSPITAL	1,875,145	4,030,436	0.465246	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	92.00
200.00		Subtotal (sum of lines 50 thru 199)	25,438,095	79,296,329		200.00
201.00		Less Observation Beds	0	0		201.00
202.00		Total (line 200 minus line 201)	25,438,095	79,296,329		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet D
Part I
Date/Time Prepared:
3/26/2021 11:01 am

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Hospital Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		4,416,775	0	4,416,775	37,665	117.26	30.00
44.00	SKILLED NURSING FACILITY		296,551		296,551	2,546	116.48	44.00
200.00	Total (lines 30 through 199)		4,713,326		4,713,326	40,211		200.00
Cost Center Description			Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
			6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		18,999	2,227,823				
44.00	SKILLED NURSING FACILITY		1,707	198,831				
200.00	Total (lines 30 through 199)		20,706	2,426,654				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet D
Part II
Date/Time Prepared:
3/26/2021 11:01 am

				Title XVIII		Hospital	PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	40,085	1,803,924	0.022221	1,008,350	22,407	54.00
60.00	06000	LABORATORY	34,195	5,662,338	0.006039	2,866,420	17,310	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	13,750	1,499,372	0.009171	759,919	6,969	65.00
66.00	06600	PHYSICAL THERAPY	286,401	17,156,195	0.016694	8,191,977	136,757	66.00
67.00	06700	OCCUPATIONAL THERAPY	94,008	15,765,240	0.005963	7,711,671	45,985	67.00
68.00	06800	SPEECH PATHOLOGY	104,242	11,799,711	0.008834	6,170,765	54,513	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	180,596	915,212	0.197327	455,856	89,953	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	221,818	10,928,062	0.020298	5,335,162	108,293	73.00
74.00	07400	RENAL DIALYSIS	9,511	731,712	0.012998	349,399	4,541	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	112,248	9,004,127	0.012466	2,526	31	90.01
90.02	09002	OTHER DAY HOSPITAL	67,081	4,030,436	0.016644	1,215	20	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	1,163,935	79,296,329		32,853,260	486,779	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-3027		Period: From 09/01/2019 To 08/31/2020		Worksheet D Part III Date/Time Prepared: 3/26/2021 11:01 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	0	30.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	0	44.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	37,665	0.00	18,999	0.00	18,999	30.00	
44.00	04400	SKILLED NURSING FACILITY		0	2,546	0.00	1,707	0.00	1,707	44.00	
200.00		Total (lines 30 through 199)		0	40,211		20,706		20,706	200.00	
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0								30.00
44.00	04400	SKILLED NURSING FACILITY	0								44.00
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet D
Part IV
Date/Time Prepared:
3/26/2021 11:01 am

Cost Center Description			Title XVIII		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet D
Part IV
Date/Time Prepared:
3/26/2021 11:01 am

Cost Center Description			Title XVIII		Hospital	PPS		
			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
	ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,803,924	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	5,662,338	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,499,372	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	17,156,195	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	15,765,240	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	11,799,711	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	915,212	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,928,062	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	731,712	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	09001	WHEATON OUTPATIENT	0	0	0	9,004,127	0.000000	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	0	4,030,436	0.000000	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	79,296,329		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet D
Part IV
Date/Time Prepared:
3/26/2021 11:01 am

Cost Center Description			Title XVIII		Hospital		PPS
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
			9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,008,350	0	0	0
60.00	06000	LABORATORY	0.000000	2,866,420	0	0	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0.000000	759,919	0	0	0
66.00	06600	PHYSICAL THERAPY	0.000000	8,191,977	0	66	0
67.00	06700	OCCUPATIONAL THERAPY	0.000000	7,711,671	0	0	0
68.00	06800	SPEECH PATHOLOGY	0.000000	6,170,765	0	42,393	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	455,856	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	5,335,162	0	0	0
74.00	07400	RENAL DIALYSIS	0.000000	349,399	0	0	0
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	WHEATON OUTPATIENT	0.000000	2,526	0	4,681	0
90.02	09002	OTHER DAY HOSPITAL	0.000000	1,215	0	22,162	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0
200.00		Total (lines 50 through 199)		32,853,260	0	69,302	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet D
Part V
Date/Time Prepared:
3/26/2021 11:01 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							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.261181	0	0	0	0	54.00
60.00	06000	LABORATORY	0.218112	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.342428	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.327585	66	0	0	22	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.244584	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.282285	42,393	0	0	11,967	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.468665	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.374831	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.591026	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	09001	WHEATON OUTPATIENT	0.397471	4,681	0	0	1,861	90.01
90.02	09002	OTHER DAY HOSPITAL	0.465246	22,162	0	0	10,311	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Subtotal (see instructions)		69,302	0	0	24,161	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		69,302	0	0	24,161	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-3027		Period: From 09/01/2019 To 08/31/2020		Worksheet D Part V Date/Time Prepared: 3/26/2021 11:01 am	
				Title XVIII		Hospital		PPS	
Cost Center Description				Costs					
				Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
				6.00	7.00				
ANCILLARY SERVICE COST CENTERS									
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0				
60.00	06000	LABORATORY		0	0				
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0				
65.00	06500	RESPIRATORY THERAPY		0	0				
66.00	06600	PHYSICAL THERAPY		0	0				
67.00	06700	OCCUPATIONAL THERAPY		0	0				
68.00	06800	SPEECH PATHOLOGY		0	0				
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0				
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0				
74.00	07400	RENAL DIALYSIS		0	0				
76.97	07697	CARDIAC REHABILITATION		0	0				
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0				
76.99	07699	LITHOTRIPSY		0	0				
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	WHEATON OUTPATIENT		0	0				
90.02	09002	OTHER DAY HOSPITAL		0	0				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0				
200.00		Subtotal (see instructions)		0	0				
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0					
202.00		Net Charges (line 200 - line 201)		0	0				

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-3027 Component CCN: 14-6129		Period: From 09/01/2019 To 08/31/2020		Worksheet D Part IV Date/Time Prepared: 3/26/2021 11:01 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	WHEATON OUTPATIENT	0	0	0	0	0	0	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-3027 Component CCN: 14-6129		Period: From 09/01/2019 To 08/31/2020		Worksheet D Part IV Date/Time Prepared: 3/26/2021 11:01 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	1,803,924	0.000000	54.00
60.00	06000	LABORATORY		0	0	0	5,662,338	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY		0	0	0	1,499,372	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	17,156,195	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	15,765,240	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	11,799,711	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	915,212	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	10,928,062	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	731,712	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	WHEATON OUTPATIENT		0	0	0	9,004,127	0.000000	90.01
90.02	09002	OTHER DAY HOSPITAL		0	0	0	4,030,436	0.000000	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	79,296,329		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-3027 Component CCN: 14-6129		Period: From 09/01/2019 To 08/31/2020		Worksheet D Part IV Date/Time Prepared: 3/26/2021 11:01 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		24,935	0	0	0	54.00
60.00	06000	LABORATORY	0.000000		155,418	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000		32,735	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000		634,621	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		598,742	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		134,953	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		16,469	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		351,347	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000		44	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000		0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000		0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	WHEATON OUTPATIENT	0.000000		127	0	0	0	90.01
90.02	09002	OTHER DAY HOSPITAL	0.000000		73	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		0	0	0	0	92.00
200.00		Total (lines 50 through 199)			1,949,464	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet D
Part I
Date/Time Prepared:
3/26/2021 11:01 am

			Title XIX		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	4,416,775	0	4,416,775	37,665	117.26	30.00
44.00	SKILLED NURSING FACILITY	296,551		296,551	2,546	116.48	44.00
200.00	Total (lines 30 through 199)	4,713,326		4,713,326	40,211		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	2,074	243,197				
44.00	SKILLED NURSING FACILITY	0	0				
200.00	Total (lines 30 through 199)	2,074	243,197				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet D
Part II
Date/Time Prepared:
3/26/2021 11:01 am

Cost Center Description			Title XIX		Hospital	PPS	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	40,085	0	0.000000	0	0 54.00
60.00	06000	LABORATORY	34,195	0	0.000000	0	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	13,750	0	0.000000	0	0 65.00
66.00	06600	PHYSICAL THERAPY	286,401	0	0.000000	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	94,008	0	0.000000	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	104,242	0	0.000000	0	0 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	180,596	0	0.000000	0	0 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	221,818	0	0.000000	0	0 73.00
74.00	07400	RENAL DIALYSIS	9,511	0	0.000000	0	0 74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	WHEATON OUTPATIENT	112,248	0	0.000000	0	0 90.01
90.02	09002	OTHER DAY HOSPITAL	67,081	0	0.000000	0	0 90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0 92.00
200.00		Total (lines 50 through 199)	1,163,935	0		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-3027		Period: From 09/01/2019 To 08/31/2020		Worksheet D Part III Date/Time Prepared: 3/26/2021 11:01 am		
					Title XIX		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	0	44.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	37,665	0.00	2,074	0	0	30.00	
44.00	04400	SKILLED NURSING FACILITY		0	2,546	0.00	0	0	0	44.00	
200.00		Total (lines 30 through 199)		0	40,211		2,074			200.00	
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0								30.00
44.00	04400	SKILLED NURSING FACILITY	0								44.00
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet D
Part IV
Date/Time Prepared:
3/26/2021 11:01 am

Cost Center Description			Title XIX		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet D
Part IV
Date/Time Prepared:
3/26/2021 11:01 am

Cost Center Description			Title XIX		Hospital		PPS	
			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								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	0	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	0	0	0	0	0.000000	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	0	0	0.000000	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-3027		Period: From 09/01/2019 To 08/31/2020		Worksheet D Part IV Date/Time Prepared: 3/26/2021 11:01 am	
Cost Center Description				Title XIX		Hospital		PPS	
				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	WHEATON OUTPATIENT	0.000000	0	0	0	0	0	90.01
90.02	09002	OTHER DAY HOSPITAL	0.000000	0	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-3027	Period: From 09/01/2019 To 08/31/2020	Worksheet D-1 Date/Time Prepared: 3/26/2021 11:01 am	
Cost Center Description		Title XVIII	Hospital	PPS	
				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			37,665	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			37,665	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)			37,665	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			18,999	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)			39,224,586	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)			39,224,586	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)			39,224,586	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,041.41	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			19,785,749	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)			19,785,749	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-3027

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

Worksheet D-1

Date/Time Prepared:
3/26/2021 11:01 am

Cost Center Description		Title XVIII			Hospital	PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					9,881,916	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					29,667,665	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)					2,227,823	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					486,779	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,714,602	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					26,953,063	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-3027

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

Worksheet D-1

Date/Time Prepared:
3/26/2021 11:01 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	4,416,775	39,224,586	0.112602	0	0	90.00
91.00 Nursing School cost	0	39,224,586	0.000000	0	0	91.00
92.00 Allied health cost	0	39,224,586	0.000000	0	0	92.00
93.00 All other Medical Education	0	39,224,586	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-3027 Component CCN: 14-6129	Period: From 09/01/2019 To 08/31/2020	Worksheet D-1 Date/Time Prepared: 3/26/2021 11:01 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,546	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,546	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)		2,546	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,707	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)		3,334,214	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)		3,334,214	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)		3,334,214	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-3027 Component CCN: 14-6129	Period: From 09/01/2019 To 08/31/2020	Worksheet D-1 Date/Time Prepared: 3/26/2021 11:01 am	
				Title XVIII		Skilled Nursing Facility	PPS
Cost Center Description		Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						3,334,214 70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						1,309.59 71.00
72.00	Program routine service cost (line 9 x line 71)						2,235,470 72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						0 73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						2,235,470 74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						0 75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						0.00 76.00
77.00	Program capital-related costs (line 9 x line 76)						0 77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						0 78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						0 79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						0 80.00
81.00	Inpatient routine service cost per diem limitation						0.00 81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						0 82.00
83.00	Reasonable inpatient routine service costs (see instructions)						2,235,470 83.00
84.00	Program inpatient ancillary services (see instructions)						583,575 84.00
85.00	Utilization review - physician compensation (see instructions)						0 85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						2,819,045 86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)						0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						0 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-3027

Period:

Worksheet D-1

Component CCN: 14-6129

From 09/01/2019
To 08/31/2020Date/Time Prepared:
3/26/2021 11:01 am

Title XVIII

Skilled Nursing
Facility

PPS

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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-3027	Period: From 09/01/2019 To 08/31/2020	Worksheet D-1 Date/Time Prepared: 3/26/2021 11:01 am
Cost Center Description		Title XIX	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			37,665 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			37,665 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)			37,665 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)			2,074 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)			41,292,666 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)			41,292,666 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)			41,292,666 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,096.31 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			2,273,747 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)			2,273,747 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-3027

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

Worksheet D-1

Date/Time Prepared:
3/26/2021 11:01 am

			Title XIX		Hospital	PPS		
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)		
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)				
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)						42.00	
	Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00	
44.00	CORONARY CARE UNIT						44.00	
45.00	BURN INTENSIVE CARE UNIT						45.00	
46.00	SURGICAL INTENSIVE CARE UNIT						46.00	
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00	
	Cost Center Description							
						1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						2,273,747	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)						243,197	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)						243,197	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						2,030,550	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
56.00	Target amount (line 54 x line 55)						0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00	Bonus payment (see instructions)						0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00	Relief payment (see instructions)						0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)						0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-3027

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

Worksheet D-1

Date/Time Prepared:
3/26/2021 11:01 am

Cost Center Description		Title XIX		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	4,416,775	41,292,666	0.106963	0	90.00
91.00	Nursing School cost	0	41,292,666	0.000000	0	91.00
92.00	Allied health cost	0	41,292,666	0.000000	0	92.00
93.00	All other Medical Education	0	41,292,666	0.000000	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-3027	Period: From 09/01/2019 To 08/31/2020	Worksheet D-3 Date/Time Prepared: 3/26/2021 11:01 am	
Cost Center Description		Title XVIII	Hospital	PPS	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		27,906,119		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.261181	1,008,350	263,362	54.00
60.00	06000 LABORATORY	0.218112	2,866,420	625,201	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.342428	759,919	260,218	65.00
66.00	06600 PHYSICAL THERAPY	0.327585	8,191,977	2,683,569	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.244584	7,711,671	1,886,151	67.00
68.00	06800 SPEECH PATHOLOGY	0.282285	6,170,765	1,741,914	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.468665	455,856	213,644	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.374831	5,335,162	1,999,784	73.00
74.00	07400 RENAL DIALYSIS	0.591026	349,399	206,504	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	09001 WHEATON OUTPATIENT	0.397471	2,526	1,004	90.01
90.02	09002 OTHER DAY HOSPITAL	0.465246	1,215	565	90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		32,853,260	9,881,916	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)		32,853,260		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-3027 Component CCN: 14-6129	Period: From 09/01/2019 To 08/31/2020	Worksheet D-3 Date/Time Prepared: 3/26/2021 11:01 am	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.261181	24,935	6,513	54.00
60.00	06000 LABORATORY	0.218112	155,418	33,899	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.342428	32,735	11,209	65.00
66.00	06600 PHYSICAL THERAPY	0.327585	634,621	207,892	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.244584	598,742	146,443	67.00
68.00	06800 SPEECH PATHOLOGY	0.282285	134,953	38,095	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.468665	16,469	7,718	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.374831	351,347	131,696	73.00
74.00	07400 RENAL DIALYSIS	0.591026	44	26	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	09001 WHEATON OUTPATIENT	0.397471	127	50	90.01
90.02	09002 OTHER DAY HOSPITAL	0.465246	73	34	90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,949,464	583,575	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		1,949,464		202.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
3/26/2021 11:01 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	0	0	0	0	0
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0	0	0	0	0
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0	0	0
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0	0	0	0
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	343,783	6,702,593	7,046,376
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	0
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	0
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000	0
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0
11.01	Uncompensated care payments	36.00	0	0	0	0	0
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	0	0	0	0	0
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	0	0	0	0	0
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	0	0	0	0	0

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
3/26/2021 11:01 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	0	0	0	0	0
17.01	Net organ aquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	0	0	0
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	0	0	0	0	0
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	0	0	0	0	0
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0
26.00	Total prospective capital payments (see instructions)	12.00	0	0	0	0	0
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.000000	0.000000	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
3/26/2021 11:01 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	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0		0	0	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	343,783	6,702,593	7,046,376	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	0	0	0	0	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	0	0	0	0	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	0	0	0	0	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			0	0	0	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
3/26/2021 11:01 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	0	0	0	0	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	0	0	0	0	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	0	0	0	0	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-3027	Period: From 09/01/2019 To 08/31/2020	Worksheet E Part B Date/Time Prepared: 3/26/2021 11:01 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		24,161	2.00
3.00	OPPS payments		8,011	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.943	5.00
6.00	Line 2 times line 5		22,784	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		35.16	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		8,011	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,759	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)		6,252	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		568	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)		6,820	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		6,820	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)		106	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		69	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		83	36.00
37.00	Subtotal (see instructions)		6,889	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		6,889	40.00
40.01	Sequestration adjustment (see instructions)		92	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		6,169	41.00
41.01	Interim payments-PARHM			41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)		628	43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		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)			93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet E-1
Part I
Date/Time Prepared:
3/26/2021 11:01 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		35,756,245		6,169	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		785,946		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		36,542,191		6,169	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		628	6.01
6.02	SETTLEMENT TO PROGRAM		611,581		0	6.02
7.00	Total Medicare program liability (see instructions)		35,930,610		6,797	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

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

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

 Worksheet E-1
 Part I
 Date/Time Prepared:
 3/26/2021 11:01 am

		Title XVIII		Skilled Nursing Facility	PPS
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider		967,793		0
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		967,793		0
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	SETTLEMENT TO PROVIDER		0		0
6.02	SETTLEMENT TO PROGRAM		1		0
7.00	Total Medicare program liability (see instructions)		967,792		0
				Contractor Number	NPR Date (Mo/Day/Yr)
				1.00	2.00
8.00	Name of Contractor	0			

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet E-1
Part II
Date/Time Prepared:
3/26/2021 11:01 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: 14-3027	Period: From 09/01/2019 To 08/31/2020	Worksheet E-3 Part III Date/Time Prepared: 3/26/2021 11:01 am
		Title XVIII	Hospital	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)		30,913,343	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0.0101	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		1,026,323	3.00
4.00	Outlier Payments		853,068	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)		12.75	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	5.01
6.00	New Teaching program adjustment. (see instructions)		0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		10.61	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)		10.61	9.00
10.00	Average Daily Census (see instructions)		102.909836	10.00
11.00	Teaching Adjustment Factor (see instructions)		0.104866	11.00
12.00	Teaching Adjustment (see instructions)		3,241,759	12.00
13.00	Total PPS Payment (see instructions)		36,034,493	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)		0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		0	15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)		0	16.00
17.00	Subtotal (see instructions)		36,034,493	17.00
18.00	Primary payer payments		0	18.00
19.00	Subtotal (line 17 less line 18).		36,034,493	19.00
20.00	Deductibles		176,396	20.00
21.00	Subtotal (line 19 minus line 20)		35,858,097	21.00
22.00	Coinsurance		233,376	22.00
23.00	Subtotal (line 21 minus line 22)		35,624,721	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		27,007	24.00
25.00	Adjusted reimbursable bad debts (see instructions)		17,555	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		22,007	26.00
27.00	Subtotal (sum of lines 23 and 25)		35,642,276	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		772,653	28.00
29.00	Other pass through costs (see instructions)		0	29.00
30.00	Outlier payments reconciliation		0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS)		0	31.00
31.01	MSP PASS THROUGH		0	31.01
31.02	MSP LLC ADJUSTMENT		0	31.02
31.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	31.50
31.99	Demonstration payment adjustment amount before sequestration		0	31.99
32.00	Total amount payable to the provider (see instructions)		36,414,929	32.00
32.01	Sequestration adjustment (see instructions)		484,319	32.01
32.02	Demonstration payment adjustment amount after sequestration		0	32.02
33.00	Interim payments		36,542,191	33.00
34.00	Tentative settlement (for contractor use only)		0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)		-611,581	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,155,455	36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4		853,068	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-3027 Component CCN: 14-6129	Period: From 09/01/2019 To 08/31/2020	Worksheet E-3 Part VI Date/Time Prepared: 3/26/2021 11:01 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		1,004,621	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		1,004,621	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		17,078	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		987,543	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Demonstration payment adjustment amount before sequestration		0	14.99
15.00	Subtotal (see instructions)		987,543	15.00
15.01	Sequestration adjustment (see instructions)		19,751	15.01
15.02	Demonstration payment adjustment amount after sequestration		0	15.02
15.75	Sequestration for non-claims based amounts (see instructions)		0	15.75
16.00	Interim payments		967,793	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)		-1	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS
Provider CCN: 14-3027
Period: From 09/01/2019 To 08/31/2020
Worksheet E-4
Date/Time Prepared: 3/26/2021 11:01 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.				13.88	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)				0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA				1.28	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)				0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))				0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)				0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)				0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)				12.60	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)				10.61	6.00
7.00	Enter the lesser of line 5 or line 6				10.61	7.00
		Primary Care	Other	Total		
		1.00	2.00	3.00		
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	10.61	10.61	8.00	
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	10.61	10.61	9.00	
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00	
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01	
11.00	Total weighted FTE count	0.00	10.61		11.00	
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	10.61		12.00	
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	11.54		13.00	
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	10.92		14.00	
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00	
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01	
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00	
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01	
17.00	Adjusted rolling average FTE count	0.00	10.92		17.00	
18.00	Per resident amount	120,926.48	114,506.72		18.00	
19.00	Approved amount for resident costs	0	1,250,413	1,250,413	19.00	
					1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)				0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)				0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)				0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)				0.00	23.00
24.00	Multiply line 22 time line 23				0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)				1,250,413	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)	18,999	1,107	3,508		26.00
27.00	Total Inpatient Days (see instructions)	37,665	37,665	37,665		27.00
28.00	Ratio of inpatient days to total inpatient days	0.504421	0.029391	0.093137		28.00
29.00	Program direct GME amount	630,735	36,751	116,460	783,946	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		2,573	8,152	10,725	30.00
31.00	Net Program direct GME amount				773,221	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-3027	Period: From 09/01/2019 To 08/31/2020	Worksheet E-4 Date/Time Prepared: 3/26/2021 11:01 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)		731,712		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)		32,907,756		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)		32,907,756		41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)		24,161		42.00
43.00	Primary payer payments (see instructions)		0		43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		24,161		44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		32,931,917		45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.999266		46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.000734		47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)		773,221		48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		772,653		49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		568		50.00

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

Provider CCN: 14-3027

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

Worksheet G

Date/Time Prepared:
3/26/2021 11:01 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	5,826,573	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	10,576,050	0	0	0	4.00
5.00	Other receivable	49,133	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	95,765	0	0	0	7.00
8.00	Prepaid expenses	69,996	0	0	0	8.00
9.00	Other current assets	1,054,346	0	0	0	9.00
10.00	Due from other funds	12,394,144	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	30,066,007	0	0	0	11.00
FIXED ASSETS						
12.00	Land	6,800,000	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	71,703,622	0	0	0	15.00
16.00	Accumulated depreciation	-14,020,924	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	8,035,219	0	0	0	19.00
20.00	Accumulated depreciation	-3,807,473	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)	68,710,444	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	9,350,337	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	9,350,337	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	108,126,788	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	345,669	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,333,485	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	1,931,835	0	0	0	43.00
44.00	Other current liabilities	2,283,058	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,894,047	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	12,726,006	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	12,726,006	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	21,620,053	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	86,506,735	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	86,506,735	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	108,126,788	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-3027

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

Worksheet G-1

Date/Time Prepared:
3/26/2021 11:01 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		89,872,350		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-4,355,962				2.00
3.00	Total (sum of line 1 and line 2)		85,516,388		0		3.00
4.00	NET CAPITAL RELEASE	1,477,412		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		1,477,412		0		10.00
11.00	Subtotal (line 3 plus line 10)		86,993,800		0		11.00
12.00	INTERCOMPANY NET ASSETS SETTLEMENTS	487,064		0		0	12.00
13.00	ROUNDING	1		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		487,065		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		86,506,735		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	NET CAPITAL RELEASE		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	INTERCOMPANY NET ASSETS SETTLEMENTS		0				12.00
13.00	ROUNDING		0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-3027

Period:
From 09/01/2019
To 08/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
3/26/2021 11:01 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	57,801,257		57,801,257	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	1,917,126		1,917,126	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	59,718,383		59,718,383	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	59,718,383		59,718,383	17.00
18.00	Ancillary services	65,847,590	440,040	66,287,630	18.00
19.00	Outpatient services	0	13,008,698	13,008,698	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER INCOME	313,444	3,722,382	4,035,826	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	125,879,417	17,171,120	143,050,537	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		86,276,586		29.00
30.00	ROUNDING	2			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		2		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		86,276,588		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-3027

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

Worksheet G-3

Date/Time Prepared:
3/26/2021 11:01 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	143,050,537	1.00
2.00	Less contractual allowances and discounts on patients' accounts	68,210,326	2.00
3.00	Net patient revenues (line 1 minus line 2)	74,840,211	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	86,276,588	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-11,436,377	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	284,068	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	398,999	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	689,543	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	2,915,843	24.00
24.50	COVID-19 PHE Funding	2,791,962	24.50
25.00	Total other income (sum of lines 6-24)	7,080,415	25.00
26.00	Total (line 5 plus line 25)	-4,355,962	26.00
27.00	OTHER CONTRIBUTIONS	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-4,355,962	29.00