

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0130	Period: From 09/01/2020 To 08/31/2021	Worksheet S Parts I-III Date/Time Prepared: 1/26/2022 3:03 pm
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 2. ☐ Manually prepared cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report 4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		Date: 1/26/2022 Time: 3:03 pm
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 BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)
 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 submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by NORTHWESTERN LAKE FOREST HOSPITAL (14-0130) for the cost reporting period beginning 09/01/2020 and ending 08/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2		
1			I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name			2
3	Signatory Title			3
4	Date			4

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	-30,193	269,413	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	-30,193	269,413	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0130		Period: From 09/01/2020 To 08/31/2021		Worksheet S-2 Part I Date/Time Prepared: 1/26/2022 3:03 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 1000 WESTMORELAND ROAD			PO Box:				1.00	
2.00	City: LAKE FOREST			State: IL		Zip Code: 60045		County: LAKE 2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			NORTHWESTERN LAKE FOREST HOSPITAL	140130	29404	1	07/01/1966	N P O 3.00
4.00	Subprovider - IPF								4.00
5.00	Subprovider - IRF								5.00
6.00	Subprovider - (Other)								6.00
7.00	Swing Beds - SNF								7.00
8.00	Swing Beds - NF								8.00
9.00	Hospital-Based SNF								9.00
10.00	Hospital-Based NF								10.00
11.00	Hospital-Based OLTC								11.00
12.00	Hospital-Based HHA								12.00
13.00	Separately Certified ASC								13.00
14.00	Hospital-Based Hospice								14.00
15.00	Hospital-Based Health Clinic - RHC								15.00
16.00	Hospital-Based Health Clinic - FQHC								16.00
17.00	Hospital-Based (CMHC) I								17.00
18.00	Renal Dialysis								18.00
19.00	Other								19.00
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						09/01/2020	08/31/2021	20.00
21.00	Type of Control (see instructions)						2		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N		23.00

Worksheet S-2
Part I
Date/Time Prepared:
1/26/2022 3:03 pm

MCRIF32 - 17.1.172.0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet S-2
Part I
Date/Time Prepared:
1/26/2022 3:03 pm

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
		1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	Y	Y		60.00	
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1	60.01	
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)					
61.02	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)					
61.03	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)					
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).					
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)					
61.06	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)					
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>						
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)				N	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet S-2
Part I
Date/Time Prepared:
1/26/2022 3:03 pm

			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0130	Period: From 09/01/2020 To 08/31/2021	Worksheet S-2 Part I Date/Time Prepared: 1/26/2022 3:03 pm	
			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00

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				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00	
				1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N				110.00	
				1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00	
		1.00	2.00	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:	355,458		1,538,885		5,275,241118.01	
				1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00	
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00	
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0130		Period: From 09/01/2020 To 08/31/2021		Worksheet S-2 Part I Date/Time Prepared: 1/26/2022 3:03 pm	
		1.00		2.00			
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		HB0640		140.00	
		1.00		2.00		3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: NORTHWESTERN MEMORIAL HEALTHCARE AND	Contractor's Name: NGS		Contractor's Number: 06101		141.00	
142.00	Street: 251 E HURON ST	PO Box:				142.00	
143.00	City: CHICAGO	State: IL		Zip Code: 60611		143.00	
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?			N		144.00	
		1.00		2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					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	
		1.00		2.00		3.00	
						Title XIX	
						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	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC			N		N	
						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	
		0		1.00		2.00	
						3.00	
						4.00	
						5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.01		169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0130	Period: From 09/01/2020 To 08/31/2021	Worksheet S-2 Part I Date/Time Prepared: 1/26/2022 3:03 pm
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0130		Period: From 09/01/2020 To 08/31/2021		Worksheet S-2 Part II Date/Time Prepared: 1/26/2022 3:03 pm	
		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				
		1.00	2.00				
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				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		11/30/2021		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N		Legal Oper.			
		1.00		2.00			
Approved Educational Activities							
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y					7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	Y					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	Y					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N			14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N			15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		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		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	12/10/2021	Y	12/10/2021		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0130	Period: From 09/01/2020 To 08/31/2021	Worksheet S-2 Part II Date/Time Prepared: 1/26/2022 3:03 pm
		Description	Y/N	Y/N
		0	1.00	3.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions			22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JOHN	VANDER LAAN	41.00
42.00	Enter the employer/company name of the cost report preparer.	NORTHWESTERN MEMORIAL HEALTHCARE		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(312) 926-6618	JVANDERL@NM.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet S-2
Part II
Date/Time Prepared:
1/26/2022 3:03 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet S-3
Part I
Date/Time Prepared:
1/26/2022 3:03 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	110	40,150	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		110	40,150	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,380	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		122	44,530	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00 NURSING FACILITY	45.00	0	0		0	20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		122			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		8	2,920			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet S-3
Part I
Date/Time Prepared:
1/26/2022 3:03 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	10,900	795	33,372			1.00
2.00	HMO and other (see instructions)	4,035	4,645				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	10,900	795	33,372			7.00
8.00	INTENSIVE CARE UNIT	2,827	34	3,649			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		389	4,015			13.00
14.00	Total (see instructions)	13,727	1,218	41,036	22.84	1,404.00	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY		0	0	0.00	0.00	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			74			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				22.84	1,404.00	27.00
28.00	Observation Bed Days		0	6,748			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	120	566			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			162			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet S-3
Part I
Date/Time Prepared:
1/26/2022 3:03 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	3,165	317	11,233	1.00
2.00 HMO and other (see instructions)			819	1,209		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	3,165	317	11,233	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY	0.00					20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet S-3
Part II
Date/Time Prepared:
1/26/2022 3:03 pm

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	111,445,459	0	111,445,459	2,844,621.00	39.18
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	1,501,110	0	1,501,110	47,504.00	31.60
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		695,470	60,072	755,542	24,868.00	30.38
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		3,885,362	0	3,885,362	36,509.00	106.42
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		29,234,773	0	29,234,773	649,642.00	45.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		27,296,587	0	27,296,587		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		205,446	0	205,446		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		353,090	0	353,090		
25.50	Home office wage-related (core)		2,698,521	0	2,698,521		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet S-3
Part II
Date/Time Prepared:
1/26/2022 3:03 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	1,159,729	-841,459	318,270	16,635.00	19.13	26.00
27.00	Administrative & General	5.00	15,612,886	-3,064,385	12,548,501	184,048.00	68.18	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	4,128,502	161,015	4,289,517	76,165.00	56.32	30.00
31.00	Laundry & Linen Service	8.00	152,625	4,153	156,778	8,431.00	18.60	31.00
32.00	Housekeeping	9.00	2,348,393	57,520	2,405,913	136,496.00	17.63	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	137,529	4,006	141,535	4,390.00	32.24	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	3,970,713	208,914	4,179,627	22,248.00	187.87	38.00
39.00	Central Services and Supply	14.00	1,592,007	50,957	1,642,964	57,000.00	28.82	39.00
40.00	Pharmacy	15.00	3,201,784	83,967	3,285,751	127,065.00	25.86	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet S-3
Part III
Date/Time Prepared:
1/26/2022 3:03 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	109,944,349	0	109,944,349	2,797,117.00	39.31	1.00
2.00	Excluded area salaries (see instructions)	695,470	60,072	755,542	24,868.00	30.38	2.00
3.00	Subtotal salaries (line 1 minus line 2)	109,248,879	-60,072	109,188,807	2,772,249.00	39.39	3.00
4.00	Subtotal other wages & related costs (see inst.)	33,120,135	0	33,120,135	686,151.00	48.27	4.00
5.00	Subtotal wage-related costs (see inst.)	29,995,108	0	29,995,108	0.00	27.47	5.00
6.00	Total (sum of lines 3 thru 5)	172,364,122	-60,072	172,304,050	3,458,400.00	49.82	6.00
7.00	Total overhead cost (see instructions)	32,304,168	-3,335,312	28,968,856	632,478.00	45.80	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet S-3
Part IV
Date/Time Prepared:
1/26/2022 3:03 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	4,915,440	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	8,774,688	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	3,881,083	9.00
10.00	Dental, Hearing and Vision Plan	380,821	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	732,269	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	288,480	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	0	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	7,775,676	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	-12,826	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	185,614	22.00
23.00	Tuition Reimbursement	375,342	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	27,296,587	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COST		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet S-3
Part V
Date/Time Prepared:
1/26/2022 3:03 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	3,885,362	27,296,587	1.00
2.00	Hospital	3,885,362	27,296,587	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021

Worksheet S-5

Date/Time Prepared:
1/26/2022 3:03 pm

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

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021

Worksheet S-5

Date/Time Prepared:
1/26/2022 3:03 pm

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

Health Financial Systems		NORTHWESTERN LAKE FOREST HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0130	Period: From 09/01/2020 To 08/31/2021	Worksheet S-10 Date/Time Prepared: 1/26/2022 3:03 pm	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.177572	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			30,420,443	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			2,212,000	5.00
6.00	Medicaid charges			287,288,731	6.00
7.00	Medicaid cost (line 1 times line 6)			51,014,435	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			18,381,992	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP			0	9.00
10.00	Stand-alone CHIP charges			0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			18,381,992	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	59,848,800	1,398,769	61,247,569	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	10,627,471	1,398,769	12,026,240	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	10,627,471	1,398,769	12,026,240	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			9,767,718	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			1,186,874	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			1,825,959	27.01
28.00	Non-Medicare bad debt expense (see instructions)			7,941,759	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			2,049,319	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			14,075,559	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			32,457,551	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021

Worksheet A

Date/Time Prepared:
1/26/2022 3:03 pm

	Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		22,893,230	22,893,230	0	22,893,230	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		13,442,145	13,442,145	0	13,442,145	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,159,729	514,813	1,674,542	18,534,662	20,209,204	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,612,886	163,920,406	179,533,292	-5,650,827	173,882,465	5.00
7.00	00700	OPERATION OF PLANT	4,128,502	15,211,482	19,339,984	-358,863	18,981,121	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	152,625	851,322	1,003,947	-52,043	951,904	8.00
9.00	00900	HOUSEKEEPING	2,348,393	2,161,747	4,510,140	57,520	4,567,660	9.00
10.00	01000	DIETARY	137,529	5,142,883	5,280,412	-2,447,059	2,833,353	10.00
11.00	01100	CAFETERIA	0	887,304	887,304	2,418,905	3,306,209	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	154,561	154,561	0	154,561	12.00
13.00	01300	NURSING ADMINISTRATION	3,970,713	1,232,944	5,203,657	-217,768	4,985,889	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,592,007	3,448,527	5,040,534	50,957	5,091,491	14.00
15.00	01500	PHARMACY	3,201,784	57,044,788	60,246,572	-57,676,757	2,569,815	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,501,110	311,764	1,812,874	0	1,812,874	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	91,727	537,047	628,774	-25,747	603,027	22.00
23.00	02300	PARAMED ED PRGM-(EMS)	0	0	0	56,447	56,447	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	20,680,697	9,853,012	30,533,709	-3,901,867	26,631,842	30.00
31.00	03100	INTENSIVE CARE UNIT	3,725,369	3,531,520	7,256,889	-551,145	6,705,744	31.00
43.00	04300	NURSERY	1,048,034	978,269	2,026,303	871,273	2,897,576	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	11,474,645	23,103,097	34,577,742	-15,067,725	19,510,017	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,761,546	1,438,969	4,200,515	-468,131	3,732,384	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,452,579	5,987,921	14,440,500	-1,641,836	12,798,664	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,309,742	458,411	1,768,153	-212,873	1,555,280	55.00
57.00	05700	CT SCAN	1,002,873	605,460	1,608,333	789	1,609,122	57.00
58.00	05800	MRI	2,417,367	1,035,903	3,453,270	-434,430	3,018,840	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,726,961	5,970,899	7,697,860	-4,660,426	3,037,434	59.00
60.00	06000	LABORATORY	4,337,310	10,750,283	15,087,593	-926,726	14,160,867	60.00
65.00	06500	RESPIRATORY THERAPY	1,985,488	996,590	2,982,078	-140,766	2,841,312	65.00
66.00	06600	PHYSICAL THERAPY	2,196,269	642,692	2,838,961	-343,839	2,495,122	66.00
68.00	06800	SPEECH PATHOLOGY	378,807	175,303	554,110	-68,510	485,600	68.00
69.00	06900	ELECTROCARDIOLOGY	1,151,826	423,845	1,575,671	-186,735	1,388,936	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	364,985	189,291	554,276	-51,185	503,091	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	7,955,196	7,955,196	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,401,428	10,401,428	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	56,897,987	56,897,987	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	575,728	171,076	746,804	-88,837	657,967	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OP PEDS ONC CLINIC	2,245,362	1,408,502	3,653,864	-376,343	3,277,521	90.01
90.02	09002	WOUND CLINIC	598,358	1,083,544	1,681,902	-278,402	1,403,500	90.02
91.00	09100	EMERGENCY	7,470,770	3,791,764	11,262,534	-1,115,905	10,146,629	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	948,268	394,875	1,343,143	-212,222	1,130,921	92.01
	OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	110,749,989	360,746,189	471,496,178	88,197	471,584,375	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	50,021	50,021	18,250	68,271	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	580,995	6,360,746	6,941,741	-87,809	6,853,932	192.00
194.00	07950	HEALTH & FITNESS CENTER	114,475	3,177,818	3,292,293	-18,638	3,273,655	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	111,445,459	370,334,774	481,780,233	0	481,780,233	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet A
Date/Time Prepared:
1/26/2022 3:03 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	6,420,236	29,313,466	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-2,290,909	11,151,236	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,223,562	23,432,766	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-52,776,012	121,106,453	5.00
7.00	00700	OPERATION OF PLANT	-9,643	18,971,478	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-1,620	950,284	8.00
9.00	00900	HOUSEKEEPING	0	4,567,660	9.00
10.00	01000	DIETARY	-810,992	2,022,361	10.00
11.00	01100	CAFETERIA	-574,160	2,732,049	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	-3,000	151,561	12.00
13.00	01300	NURSING ADMINISTRATION	-191,807	4,794,082	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-168	5,091,323	14.00
15.00	01500	PHARMACY	-36,467	2,533,348	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	1,812,874	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	-16,476	586,551	22.00
23.00	02300	PARAMED ED PRGM-(EMS)	0	56,447	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-5,155	26,626,687	30.00
31.00	03100	INTENSIVE CARE UNIT	-2,500	6,703,244	31.00
43.00	04300	NURSERY	0	2,897,576	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-1,623	19,508,394	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-79,128	3,653,256	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-127,030	12,671,634	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-513	1,554,767	55.00
57.00	05700	CT SCAN	-10,553	1,598,569	57.00
58.00	05800	MRI	-87,811	2,931,029	58.00
59.00	05900	CARDIAC CATHETERIZATION	-13,682	3,023,752	59.00
60.00	06000	LABORATORY	-223,074	13,937,793	60.00
65.00	06500	RESPIRATORY THERAPY	-16,065	2,825,247	65.00
66.00	06600	PHYSICAL THERAPY	-254	2,494,868	66.00
68.00	06800	SPEECH PATHOLOGY	0	485,600	68.00
69.00	06900	ELECTROCARDIOLOGY	-4,028	1,384,908	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	503,091	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,955,196	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,401,428	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	56,897,987	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	-255	657,712	76.97
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OP PEDS ONC CLINIC	-1,293	3,276,228	90.01
90.02	09002	WOUND CLINIC	-471	1,403,029	90.02
91.00	09100	EMERGENCY	-16,068	10,130,561	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	1,130,921	92.01
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-47,656,959	423,927,416	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	68,271	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,853,932	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	3,273,655	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-47,656,959	434,123,274	200.00

RECLASSIFICATIONS

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet A-6
Date/Time Prepared:
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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - MED SUPPLY & IMPLANT RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	7,955,196		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	10,401,428		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
	TOTALS		0	18,356,624		
	B - ORGANIZATION INCENTIVE					
1.00	OPERATION OF PLANT	7.00	161,015	0		1.00
2.00	LAUNDRY & LINEN SERVICE	8.00	4,153	0		2.00
3.00	HOUSEKEEPING	9.00	57,520	0		3.00
4.00	DIETARY	10.00	4,006	0		4.00
5.00	NURSING ADMINISTRATION	13.00	208,490	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	50,957	0		6.00
7.00	PHARMACY	15.00	83,967	0		7.00
8.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	2,559	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	510,128	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	84,463	0		10.00
11.00	NURSERY	43.00	16,611	0		11.00
12.00	OPERATING ROOM	50.00	281,181	0		12.00
13.00	DELIVERY ROOM & LABOR ROOM	52.00	73,628	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	192,366	0		14.00
15.00	RADIOLOGY-THERAPEUTIC	55.00	48,610	0		15.00
16.00	CT SCAN	57.00	34,276	0		16.00
17.00	MRI	58.00	60,863	0		17.00
18.00	CARDIAC CATHETERIZATION	59.00	36,104	0		18.00
19.00	LABORATORY	60.00	99,562	0		19.00
20.00	RESPIRATORY THERAPY	65.00	48,106	0		20.00
21.00	PHYSICAL THERAPY	66.00	68,268	0		21.00
22.00	SPEECH PATHOLOGY	68.00	8,172	0		22.00
23.00	ELECTROCARDIOLOGY	69.00	26,810	0		23.00
24.00	ELECTROENCEPHALOGRAPHY	70.00	7,372	0		24.00
25.00	CARDIAC REHABILITATION	76.97	13,344	0		25.00
26.00	OP PEDS ONC CLINIC	90.01	52,760	0		26.00
27.00	WOUND CLINIC	90.02	21,435	0		27.00
28.00	EMERGENCY	91.00	188,201	0		28.00
29.00	HEALTH & FITNESS CENTER	194.00	3,625	0		29.00
	TOTALS		2,448,552	0		
	C - DRUG RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	56,897,987		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
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
	TOTALS		0	56,897,987		

RECLASSIFICATIONS

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021

Worksheet A-6

Date/Time Prepared:
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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	D - ADMINISTRATIVE RADIOLOGY RECLASS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	354,530	135,799	1.00	
2.00	CT SCAN	57.00	190,754	73,067	2.00	
3.00	MRI	58.00	212,683	81,466	3.00	
4.00	PHYSICAL THERAPY	66.00	14,121	5,409	4.00	
5.00	ELECTROENCEPHALOGRAPHY	70.00	7,017	2,688	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
	TOTALS		779,105	298,429		
	E - RESTRICTED FUNDS RECLASS					
1.00	NURSING ADMINISTRATION	13.00	424	4,793	1.00	
2.00	ADULTS & PEDIATRICS	30.00	93,541	535,272	2.00	
3.00	CARDIAC CATHETERIZATION	59.00	126,460	19,551	3.00	
4.00	RESPIRATORY THERAPY	65.00	205,843	15,434	4.00	
5.00	PHYSICAL THERAPY	66.00	4,457	611	5.00	
6.00	ELECTROENCEPHALOGRAPHY	70.00	189,273	44,851	6.00	
7.00	CARDIAC REHABILITATION	76.97	1,742	131	7.00	
8.00	LABORATORY	60.00	0	13,217	8.00	
9.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	18,250	9.00	
10.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	46,022	10.00	
	TOTALS		621,740	698,132		
	H - NURSERY RECLASS					
1.00	NURSERY	43.00	703,613	321,810	1.00	
	TOTALS		703,613	321,810		
	J - DIETARY RECLASS					
1.00	CAFETERIA	11.00	0	2,418,905	1.00	
	TOTALS		0	2,418,905		
	K - EMPL BENE RCL ACCR TO NON SALARY					
1.00	ADMINISTRATIVE & GENERAL	5.00	841,459	0	1.00	
	TOTALS		841,459	0		
	M - ACCOUNT 648000 RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	19,376,121	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
5.00		0.00	0	0	5.00	
7.00		0.00	0	0	7.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
23.00		0.00	0	0	23.00	
24.00		0.00	0	0	24.00	
25.00		0.00	0	0	25.00	
26.00		0.00	0	0	26.00	
27.00		0.00	0	0	27.00	
28.00		0.00	0	0	28.00	
29.00		0.00	0	0	29.00	
30.00		0.00	0	0	30.00	
31.00		0.00	0	0	31.00	
32.00		0.00	0	0	32.00	
33.00		0.00	0	0	33.00	
	TOTALS		0	19,376,121		
	N - EMS PARAMED ED PROGRAM					
1.00	PARAMED ED PRGM-(EMS)	23.00	56,447	0	1.00	
	TOTALS		56,447	0		
500.00	Grand Total: Increases		5,450,916	98,368,008	500.00	

RECLASSIFICATIONS

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet A-6
Date/Time Prepared:
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		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
	A - MED SUPPLY & IMPLANT RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	0	8,013	0		1.00	
2.00	INTENSIVE CARE UNIT	31.00	0	4,400	0		2.00	
3.00	NURSERY	43.00	0	2	0		3.00	
4.00	OPERATING ROOM	50.00	0	5,947,696	0		4.00	
5.00	DELIVERY ROOM & LABOR ROOM	52.00	0	40,717	0		5.00	
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	33,067	0		6.00	
7.00	CT SCAN	57.00	0	1,694	0		7.00	
8.00	MRI	58.00	0	246	0		8.00	
9.00	CARDIAC CATHETERIZATION	59.00	0	1,829,371	0		9.00	
10.00	RESPIRATORY THERAPY	65.00	0	59,655	0		10.00	
11.00	SPEECH PATHOLOGY	68.00	0	381	0		11.00	
12.00	ELECTROENCEPHALOGRAPHY	70.00	0	4,716	0		12.00	
13.00	OP PEDS ONC CLINIC	90.01	0	15,833	0		13.00	
14.00	WOUND CLINIC	90.02	0	3,875	0		14.00	
15.00	EMERGENCY	91.00	0	5,457	0		15.00	
16.00	OBSERVATION BEDS (DISTINCT PART)	92.01	0	73	0		16.00	
17.00	OPERATING ROOM	50.00	0	7,710,943	0		17.00	
18.00	CARDIAC CATHETERIZATION	59.00	0	2,690,485	0		18.00	
	TOTALS		0	18,356,624				
	B - ORGANIZATION INCENTIVE							
1.00	ADMINISTRATIVE & GENERAL	5.00	2,448,552	0	0		1.00	
2.00		0.00	0	0	0		2.00	
3.00		0.00	0	0	0		3.00	
4.00		0.00	0	0	0		4.00	
5.00		0.00	0	0	0		5.00	
6.00		0.00	0	0	0		6.00	
7.00		0.00	0	0	0		7.00	
8.00		0.00	0	0	0		8.00	
9.00		0.00	0	0	0		9.00	
10.00		0.00	0	0	0		10.00	
11.00		0.00	0	0	0		11.00	
12.00		0.00	0	0	0		12.00	
13.00		0.00	0	0	0		13.00	
14.00		0.00	0	0	0		14.00	
15.00		0.00	0	0	0		15.00	
16.00		0.00	0	0	0		16.00	
17.00		0.00	0	0	0		17.00	
18.00		0.00	0	0	0		18.00	
19.00		0.00	0	0	0		19.00	
20.00		0.00	0	0	0		20.00	
21.00		0.00	0	0	0		21.00	
22.00		0.00	0	0	0		22.00	
23.00		0.00	0	0	0		23.00	
24.00		0.00	0	0	0		24.00	
25.00		0.00	0	0	0		25.00	
26.00		0.00	0	0	0		26.00	
27.00		0.00	0	0	0		27.00	
28.00		0.00	0	0	0		28.00	
29.00		0.00	0	0	0		29.00	
	TOTALS		2,448,552	0				
	C - DRUG RECLASS							
1.00		0.00	0	0	0		1.00	
2.00	PHARMACY	15.00	0	56,895,646	0		2.00	
3.00	ADULTS & PEDIATRICS	30.00	0	97	0		3.00	
4.00	INTENSIVE CARE UNIT	31.00	0	11	0		4.00	
5.00	OPERATING ROOM	50.00	0	171	0		5.00	
6.00	DELIVERY ROOM & LABOR ROOM	52.00	0	35	0		6.00	
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	78	0		7.00	
8.00	CT SCAN	57.00	0	345	0		8.00	
9.00	MRI	58.00	0	311	0		9.00	
10.00	CARDIAC CATHETERIZATION	59.00	0	655	0		10.00	
11.00	LABORATORY	60.00	0	118	0		11.00	
12.00	RADIOLOGY-THERAPEUTIC	55.00	0	6	0		12.00	
14.00	OP PEDS ONC CLINIC	90.01	0	73	0		14.00	
15.00	WOUND CLINIC	90.02	0	306	0		15.00	
16.00	EMERGENCY	91.00	0	135	0		16.00	
	TOTALS		0	56,897,987				
	D - ADMINISTRATIVE RADIOLOGY RECLASS							
1.00		0.00	0	0	0		1.00	
2.00		0.00	0	0	0		2.00	
3.00		0.00	0	0	0		3.00	
4.00		0.00	0	0	0		4.00	

RECLASSIFICATIONS

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet A-6
Date/Time Prepared:
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	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
5.00		0.00	0	0	0		5.00
6.00	ADMINISTRATIVE & GENERAL	5.00	779,105	0	0		6.00
7.00	ADMINISTRATIVE & GENERAL	5.00	0	298,429	0		7.00
	TOTALS		779,105	298,429			
E - RESTRICTED FUNDS RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	424	4,793	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	93,541	535,272	0		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	126,460	19,551	0		3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	205,843	15,434	0		4.00
5.00	ADMINISTRATIVE & GENERAL	5.00	4,457	611	0		5.00
6.00	ADMINISTRATIVE & GENERAL	5.00	189,273	44,851	0		6.00
7.00	ADMINISTRATIVE & GENERAL	5.00	1,742	131	0		7.00
8.00	ADMINISTRATIVE & GENERAL	5.00	0	13,217	0		8.00
9.00	ADMINISTRATIVE & GENERAL	5.00	0	18,250	0		9.00
10.00	ADMINISTRATIVE & GENERAL	5.00	0	46,022	0		10.00
	TOTALS		621,740	698,132			
H - NURSERY RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	703,613	321,810	0		1.00
	TOTALS		703,613	321,810			
J - DIETARY RECLASS							
1.00	DIETARY	10.00	0	2,418,905	0		1.00
	TOTALS		0	2,418,905			
K - EMPL BENE RCL ACCR TO NON SALARY							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	841,459	0	0		1.00
	TOTALS		841,459	0			
M - ACCOUNT 648000 RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,589,881	0		1.00
2.00	OPERATION OF PLANT	7.00	0	519,878	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	56,196	0		3.00
5.00	DIETARY	10.00	0	32,160	0		5.00
7.00	NURSING ADMINISTRATION	13.00	0	431,475	0		7.00
9.00	PHARMACY	15.00	0	865,078	0		9.00
10.00	I&R SERVICES-OTHER PRGM	22.00	0	28,306	0		10.00
	COSTS APPRV						
11.00	ADULTS & PEDIATRICS	30.00	0	4,007,275	0		11.00
12.00	INTENSIVE CARE UNIT	31.00	0	631,197	0		12.00
13.00	NURSERY	43.00	0	170,759	0		13.00
14.00	OPERATING ROOM	50.00	0	1,690,096	0		14.00
15.00	DELIVERY ROOM & LABOR ROOM	52.00	0	501,007	0		15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,291,386	0		16.00
17.00	RADIOLOGY-THERAPEUTIC	55.00	0	261,477	0		17.00
18.00	CT SCAN	57.00	0	295,269	0		18.00
19.00	MRI	58.00	0	788,885	0		19.00
20.00	CARDIAC CATHETERIZATION	59.00	0	322,030	0		20.00
21.00	LABORATORY	60.00	0	1,039,387	0		21.00
22.00	RESPIRATORY THERAPY	65.00	0	350,494	0		22.00
23.00	PHYSICAL THERAPY	66.00	0	436,705	0		23.00
24.00	SPEECH PATHOLOGY	68.00	0	76,301	0		24.00
25.00	ELECTROCARDIOLOGY	69.00	0	213,545	0		25.00
26.00	ELECTROENCEPHALOGRAPHY	70.00	0	297,670	0		26.00
27.00	CARDIAC REHABILITATION	76.97	0	104,054	0		27.00
28.00	OP PEDS ONC CLINIC	90.01	0	413,197	0		28.00
29.00	WOUND CLINIC	90.02	0	295,656	0		29.00
30.00	EMERGENCY	91.00	0	1,298,514	0		30.00
31.00	OBSERVATION BEDS (DISTINCT PART)	92.01	0	212,149	0		31.00
32.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	133,831	0		32.00
33.00	HEALTH & FITNESS CENTER	194.00	0	22,263	0		33.00
	TOTALS		0	19,376,121			
N - EMS PARAMED ED PROGRAM							
1.00	ADMINISTRATIVE & GENERAL	5.00	56,447	0	0		1.00
	TOTALS		56,447	0			
500.00	Grand Total: Decreases		5,450,916	98,368,008			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet A-7
Part I
Date/Time Prepared:
1/26/2022 3:03 pm

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet A-7
Part II
Date/Time Prepared:
1/26/2022 3:03 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	22,446,145	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	14,225,838	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	36,671,983	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	447,085	22,893,230				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	-783,693	13,442,145				2.00
3.00	Total (sum of lines 1-2)	-336,608	36,335,375				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet A-7
Part III
Date/Time Prepared:
1/26/2022 3:03 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	534,605,793	0	534,605,793	0.824302	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	113,949,670	0	113,949,670	0.175698	0	2.00
3.00	Total (sum of lines 1-2)	648,555,463	0	648,555,463	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	28,866,381	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	11,934,929	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	40,801,310	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	447,085	29,313,466	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	-783,693	11,151,236	2.00
3.00	Total (sum of lines 1-2)	0	0	0	-336,608	40,464,702	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021

Worksheet A-8

Date/Time Prepared:
1/26/2022 3:03 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)			0	0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)			0	0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)			0	0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)			0	0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)			0	0.00	0	7.00
8.00	Television and radio service (chapter 21)			0	0.00	0	8.00
9.00	Parking lot (chapter 21)			0	0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2		0		0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)			0	0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-33,095,776			0	12.00
13.00	Laundry and linen service			0	0.00	0	13.00
14.00	Cafeteria-employees and guests			0	0.00	0	14.00
15.00	Rental of quarters to employee and others			0	0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients			0	0.00	0	16.00
17.00	Sale of drugs to other than patients			0	0.00	0	17.00
18.00	Sale of medical records and abstracts			0	0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)			0	0.00	0	19.00
19.01	Nursing and allied health education (tuition, fees, books, etc.)			0	0.00	0	19.01
19.02	Nursing and allied health education (tuition, fees, books, etc.)			0	0.00	0	19.02
20.00	Vending machines			0	0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)			0	0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0	0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL 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			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021

Worksheet A-8

Date/Time Prepared:
1/26/2022 3:03 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
43.17	3416430800CORPORATE BILLING REVENUE	B	-6,693	LABORATORY	60.00	0	43.17
43.18	3418430800CORPORATE BILLING REVENUE	B	-236	LABORATORY	60.00	0	43.18
43.19	3419430800CORPORATE BILLING REVENUE	B	-1,050	LABORATORY	60.00	0	43.19
43.20	3420430800CORPORATE BILLING REVENUE	B	-74	LABORATORY	60.00	0	43.20
43.21	3575430800CORPORATE BILLING REVENUE	B	-6,137	LABORATORY	60.00	0	43.21
43.22	3550430800CORPORATE BILLING REVENUE	B	-10,421	EMERGENCY	91.00	0	43.22
43.23	3390430850RESEARCH REVENUE	B	-1,186	PHARMACY	15.00	0	43.23
43.24	3311430850RESEARCH REVENUE	B	-172	OPERATING ROOM	50.00	0	43.24
43.25	3314430850RESEARCH REVENUE	B	-385	OPERATING ROOM	50.00	0	43.25
43.26	3349430850RESEARCH REVENUE	B	-1,979	RADIOLOGY-DIAGNOSTIC	54.00	0	43.26
43.27	3443430850RESEARCH REVENUE	B	-648	RADIOLOGY-DIAGNOSTIC	54.00	0	43.27
43.28	3445430850RESEARCH REVENUE	B	-2,341	RADIOLOGY-DIAGNOSTIC	54.00	0	43.28
43.34	3562430850RESEARCH REVENUE	B	-324	RADIOLOGY-DIAGNOSTIC	54.00	0	43.34
43.35	3345430850RESEARCH REVENUE	B	-1,221	CT SCAN	57.00	0	43.35
43.36	3561430850RESEARCH REVENUE	B	-6,004	MRI	58.00	0	43.36
43.37	3285430850RESEARCH REVENUE	B	-27	CARDIAC CATHETERIZATION	59.00	0	43.37
43.38	3413430850RESEARCH REVENUE	B	-123	LABORATORY	60.00	0	43.38
43.39	3415430850RESEARCH REVENUE	B	-87	LABORATORY	60.00	0	43.39
43.40	3416430850RESEARCH REVENUE	B	-12	LABORATORY	60.00	0	43.40
43.41	3419430850RESEARCH REVENUE	B	-18	LABORATORY	60.00	0	43.41
43.42	3575430850RESEARCH REVENUE	B	-512	LABORATORY	60.00	0	43.42
43.43	3280430850RESEARCH REVENUE	B	-1,089	ELECTROCARDIOLOGY	69.00	0	43.43
43.44	3565430850RESEARCH REVENUE	B	-2,939	ELECTROCARDIOLOGY	69.00	0	43.44
43.45	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.45
43.46	3415431000CORPORATE BILLING ADJUSTME	B	-101	LABORATORY	60.00	0	43.46
43.47	3125432500IC SHARED SERVICES INCOME	B	-1,620	LAUNDRY & LINEN SERVICE	8.00	0	43.47
43.48	3050434401IC LEASE EMPLOYEES REV	B	-22,667	ADMINISTRATIVE & GENERAL	5.00	0	43.48
43.49	3215434401IC LEASE EMPLOYEES REV	B	-172,997	NURSING ADMINISTRATION	13.00	0	43.49
43.50	3390434401IC LEASE EMPLOYEES REV	B	-34,538	PHARMACY	15.00	0	43.50
43.51	3270434401IC LEASE EMPLOYEES REV	B	-15,867	RESPIRATORY THERAPY	65.00	0	43.51
43.52	32924382000OTHER OPERATING INCOME	B	-63,000	ADMINISTRATIVE & GENERAL	5.00	0	43.52
43.53	33414382000OTHER OPERATING INCOME	B	-3,881	ADMINISTRATIVE & GENERAL	5.00	0	43.53
43.54	31614382000OTHER OPERATING INCOME	B	-200	DIETARY	10.00	0	43.54
43.55	37234382000OTHER OPERATING INCOME	B	-500	MAINTENANCE OF PERSONNEL	12.00	0	43.55
43.56	3036469999PAYOR INTEREST INCOME	B	-132,299	ADMINISTRATIVE & GENERAL	5.00	0	43.56
43.57	3719415225RENTALREVENUE	B	-360,958	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	43.57
43.58	3440415225RENTALREVENUE	B	-49,881	RADIOLOGY-DIAGNOSTIC	54.00	0	43.58
43.59	3035793000IDPAMEDICAIDTAX	A	-13,734,059	ADMINISTRATIVE & GENERAL	5.00	0	43.59
43.60	615201PHYSICIANLEADERSHIP	B	-1,858,392	ADMINISTRATIVE & GENERAL	5.00	0	43.60
43.61	EXCLUDED ACCOUNTS	A	-273,218	ADMINISTRATIVE & GENERAL	5.00	0	43.61
43.62	EXCLUDED ACCOUNTS	A	-9,643	OPERATION OF PLANT	7.00	0	43.62
43.63	EXCLUDED ACCOUNTS	A	-264	DIETARY	10.00	0	43.63
43.64	EXDLUED ACCOUNTS	A	-18,810	NURSING ADMINISTRATION	13.00	0	43.64
43.65	EXCLUDED ACCOUNTS	A	-168	CENTRAL SERVICES & SUPPLY	14.00	0	43.65
43.66	EXCLUDED ACCOUNTS	A	-708	PHARMACY	15.00	0	43.66
43.67	EXCLUDED ACCOUNTS	A	-16,476	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	43.67
43.68	EXCLUDED ACCOUNTS	A	-5,155	ADULTS & PEDIATRICS	30.00	0	43.68
43.69	EXCLUDED ACCOUNTS	A	-2,500	INTENSIVE CARE UNIT	31.00	0	43.69
43.70	EXCLUDED ACCOUNTS	A	-1,066	OPERATING ROOM	50.00	0	43.70
43.71	EXCLUDED ACCOUNTS	A	-319	DELIVERY ROOM & LABOR ROOM	52.00	0	43.71
43.72	EXCLUDED ACCOUNTS	A	-1,818	RADIOLOGY-DIAGNOSTIC	54.00	0	43.72

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021

Worksheet A-8

Date/Time Prepared:
1/26/2022 3:03 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
43.73	EXCLUDED ACCOUNTS	A	-513	RADIOLOGY-THERAPEUTIC	55.00	0	43.73
43.74	EXCLUDED ACCOUNTS	A	-9,332	CT SCAN	57.00	0	43.74
43.75	EXCLUDED ACCOUNTS	A	-48,021	MRI	58.00	0	43.75
43.76	EXCLUDED ACCOUNTS	A	-13,655	CARDIAC CATHETERIZATION	59.00	0	43.76
43.77	EXCLUDED ACCOUNTS	A	-3,065	LABORATORY	60.00	0	43.77
43.78	EXCLUDED ACCOUNTS	A	-198	RESPIRATORY THERAPY	65.00	0	43.78
43.79	EXCLUDED ACCOUNTS	A	-254	PHYSICAL THERAPY	66.00	0	43.79
43.80	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.80
43.81	EXCLUDED ACCOUNTS	A	-255	CARDIAC REHABILITATION	76.97	0	43.81
43.82	EXCLUDED ACCOUNTS	A	-1,293	OP PEDS ONC CLINIC	90.01	0	43.82
43.83	EXCLUDED ACCOUNTS	A	-471	WOUND CLINIC	90.02	0	43.83
43.84	EXCLUDED ACCOUNTS	A	-4,946	EMERGENCY	91.00	0	43.84
43.85	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.85
43.86	EXCLUDE GAIN ON DISPOSAL	A	116,645	CAP REL COSTS-MVBLE EQUIP	2.00	9	43.86
43.87	ADJUST TO MEDICARE DEPRECIATION	A	6,420,236	CAP REL COSTS-BLDG & FIXT	1.00	9	43.87
43.88	ADJUST TO MEDICARE DEPRECIATION	A	-2,407,554	CAP REL COSTS-MVBLE EQUIP	2.00	9	43.88
43.89	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.89
43.90	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.90
43.91	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.91
43.92	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.92
43.93	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.93
43.94	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.94
43.95	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.95
43.96	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.96
43.97	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.97
43.98	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.98
43.99	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.99
44.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.00
44.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.01
44.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.02
44.03	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.03
44.04	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.04
44.05	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.05
44.06	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.06
44.07	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.07
44.08	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.08
44.09	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.09
44.10	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.10
44.11	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.11
44.12	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.12
44.13	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.13

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021

Worksheet A-8

Date/Time Prepared:
1/26/2022 3:03 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
44.14	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.14
44.15	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.15
44.16	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.16
44.17	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.17
44.18	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.18
44.19	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.19
44.20	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.20
44.21	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.21
44.22	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.22
44.23	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.23
44.24	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.24
44.25	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.25
44.26	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.26
44.27	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.27
44.28	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.28
44.29	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.29
44.30	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.30
44.31	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.31
44.32	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.32
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-47,656,959				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021

Worksheet A-8-1

Date/Time Prepared:
1/26/2022 3:03 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	0.00			0	0	1.00
2.00	0.00			0	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	MANAGEMENT CHARGE	23,073,617	19,489,097	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT CHARGE	57,639,103	94,319,399	3.01
3.02	0.00			0	0	3.02
3.03	0.00			0	0	3.03
3.04	0.00			0	0	3.04
3.05	0.00			0	0	3.05
3.06	0.00			0	0	3.06
3.07	0.00			0	0	3.07
3.08	0.00			0	0	3.08
3.09	0.00			0	0	3.09
3.10	0.00			0	0	3.10
3.11	0.00			0	0	3.11
3.12	0.00			0	0	3.12
3.13	0.00			0	0	3.13
3.14	0.00			0	0	3.14
3.15	0.00			0	0	3.15
3.16	0.00			0	0	3.16
3.17	0.00			0	0	3.17
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			80,712,720	113,808,496	5.00

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

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

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

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

6.00	B	0.00	NM HEALTHCARE	100.00	6.00
7.00	B	0.00	NM HOSPITAL	100.00	7.00
8.00	B	0.00	NM FOUNDATION	100.00	8.00
9.00	B	0.00	NM MEDICAL GROUP	100.00	9.00
9.01	B	0.00	LF HEALTH AND FITNESS INSTITUTE	100.00	9.01
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021

Worksheet A-8-1

Date/Time Prepared:
1/26/2022 3:03 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	0	0		1.00
2.00	0	0		2.00
3.00	3,584,520	0		3.00
3.01	-36,680,296	0		3.01
3.02	0	0		3.02
3.03	0	0		3.03
3.04	0	0		3.04
3.05	0	0		3.05
3.06	0	0		3.06
3.07	0	0		3.07
3.08	0	0		3.08
3.09	0	0		3.09
3.10	0	0		3.10
3.11	0	0		3.11
3.12	0	0		3.12
3.13	0	0		3.13
3.14	0	0		3.14
3.15	0	0		3.15
3.16	0	0		3.16
3.17	0	0		3.17
4.00	0	0		4.00
5.00	-33,095,776			5.00

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

	Related Organization(s) and/or Home Office	
	Type of Business	
	6.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

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

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

6.00	HEALTHCARE		6.00
7.00	HEALTHCARE		7.00
8.00	HEALTHCARE		8.00
9.00	HEALTHCARE		9.00
9.01	HEALTHCARE		9.01
10.00			10.00
100.00			100.00

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

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet B
Part I
Date/Time Prepared:
1/26/2022 3:03 pm

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	29,313,466	29,313,466				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	11,151,236		11,151,236			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	23,432,766	0	0	23,432,766		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	121,106,453	1,813,598	2,081,114	3,510,413	128,511,578	5.00
7.00	00700	OPERATION OF PLANT	18,971,478	12,222,129	403,367	868,769	32,465,743	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	950,284	22,265	0	32,117	1,004,666	8.00
9.00	00900	HOUSEKEEPING	4,567,660	74,898	40,598	494,177	5,177,333	9.00
10.00	01000	DIETARY	2,022,361	306,748	0	28,941	2,358,050	10.00
11.00	01100	CAFETERIA	2,732,049	0	3,471	0	2,735,520	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	151,561	0	0	0	151,561	12.00
13.00	01300	NURSING ADMINISTRATION	4,794,082	59,004	60,957	835,565	5,749,608	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,091,323	135,136	5,443	335,009	5,566,911	14.00
15.00	01500	PHARMACY	2,533,348	129,484	240,116	673,758	3,576,706	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,812,874	0	0	315,882	2,128,756	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	586,551	0	0	19,302	605,853	22.00
23.00	02300	PARAMED ED PRGM-(EMS)	56,447	0	0	0	56,447	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	26,626,687	2,703,249	255,564	4,351,826	33,937,326	30.00
31.00	03100	INTENSIVE CARE UNIT	6,703,244	335,697	202,072	783,937	8,024,950	31.00
43.00	04300	NURSERY	2,897,576	118,501	12,193	220,540	3,248,810	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	19,508,394	1,822,037	551,191	2,414,632	24,296,254	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,653,256	408,929	129,493	581,118	4,772,796	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,671,634	301,669	2,476,832	1,778,693	17,228,828	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,554,767	656,868	454,529	275,612	2,941,776	55.00
57.00	05700	CT SCAN	1,598,569	113,170	1,154,168	211,037	3,076,944	57.00
58.00	05800	MRI	2,931,029	145,703	750,647	508,691	4,336,070	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,023,752	220,559	889,279	363,408	4,496,998	59.00
60.00	06000	LABORATORY	13,937,793	198,386	422,522	912,709	15,471,410	60.00
65.00	06500	RESPIRATORY THERAPY	2,825,247	39,527	63,083	417,810	3,345,667	65.00
66.00	06600	PHYSICAL THERAPY	2,494,868	0	64,127	462,165	3,021,160	66.00
68.00	06800	SPEECH PATHOLOGY	485,600	59,077	25,624	79,713	650,014	68.00
69.00	06900	ELECTROCARDIOLOGY	1,384,908	162,755	91,891	242,381	1,881,935	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	503,091	75,283	251,324	76,805	906,503	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,955,196	0	0	0	7,955,196	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,401,428	0	0	0	10,401,428	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	56,897,987	0	0	0	56,897,987	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	657,712	322,356	27,975	121,152	1,129,195	76.97
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	3,276,228	241,389	6,454	472,496	3,996,567	90.01
90.02	09002	WOUND CLINIC	1,403,029	166,282	6,233	125,914	1,701,458	90.02
91.00	09100	EMERGENCY	10,130,561	698,011	138,032	1,572,089	12,538,693	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1,130,921	184,721	3,267	199,546	1,518,455	92.01
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	423,927,416	23,737,431	10,811,566	23,286,207	417,865,152	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	68,271	0	366	0	68,637	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,853,932	5,576,035	269,094	122,470	12,821,531	192.00
194.00	07950	HEALTH & FITNESS CENTER	3,273,655	0	70,210	24,089	3,367,954	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	434,123,274	29,313,466	11,151,236	23,432,766	434,123,274	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet B
Part I
Date/Time Prepared:
1/26/2022 3:03 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	128,511,578					5.00
7.00	00700	OPERATION OF PLANT	14,249,864	46,715,607				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	440,968	0	1,445,634			8.00
9.00	00900	HOUSEKEEPING	2,272,435	363,156	762,458	8,575,382		9.00
10.00	01000	DIETARY	1,034,995	1,353,648	0	135,117	4,881,810	10.00
11.00	01100	CAFETERIA	1,200,674	0	0	36,032	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	66,523	0	0	18,015	0	12.00
13.00	01300	NURSING ADMINISTRATION	2,523,618	260,380	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,443,429	606,527	0	90,077	0	14.00
15.00	01500	PHARMACY	1,569,888	572,509	0	54,047	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	198,171	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	934,354	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	265,921	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(EMS)	24,776	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,895,771	11,929,147	417,012	5,062,355	3,722,257	30.00
31.00	03100	INTENSIVE CARE UNIT	3,522,311	1,481,395	46,165	405,350	406,892	31.00
43.00	04300	NURSERY	1,425,968	522,930	105,826	126,109	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,664,112	8,128,584	26,052	936,806	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,094,876	1,804,563	31,446	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,562,077	4,804,447	0	216,186	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,291,204	1,578,563	0	0	0	55.00
57.00	05700	CT SCAN	1,350,532	499,408	0	0	0	57.00
58.00	05800	MRI	1,903,188	652,668	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,973,822	973,302	0	0	0	59.00
60.00	06000	LABORATORY	6,790,711	895,134	0	270,232	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,468,480	174,431	0	81,070	0	65.00
66.00	06600	PHYSICAL THERAPY	1,326,048	0	6,463	99,085	0	66.00
68.00	06800	SPEECH PATHOLOGY	285,304	702,609	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	826,019	748,750	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	397,882	332,215	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,491,695	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,565,395	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,973,784	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	495,626	2,515,857	3,140	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	1,754,173	1,065,222	0	423,365	0	90.01
90.02	09002	WOUND CLINIC	746,804	739,883	47,072	0	0	90.02
91.00	09100	EMERGENCY	5,503,483	3,195,123	0	351,303	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	666,480	815,156	0	0	752,661	92.01
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	127,003,190	46,715,607	1,445,634	8,503,320	4,881,810	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	30,126	0	0	72,062	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HEALTH & FITNESS CENTER	1,478,262	0	0	0	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	128,511,578	46,715,607	1,445,634	8,575,382	4,881,810	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet B
Part I
Date/Time Prepared:
1/26/2022 3:03 pm

Cost Center Description			CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	3,972,226					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	236,099				12.00
13.00	01300	NURSING ADMINISTRATION	100,405	0	8,634,011			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,646	0	0	8,709,590		14.00
15.00	01500	PHARMACY	201,473	0	0	0	5,974,623	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	6,599	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(EMS)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	957,030	0	3,397,422	173,299	72,376	30.00
31.00	03100	INTENSIVE CARE UNIT	162,913	0	738,263	16,518	3,569	31.00
43.00	04300	NURSERY	40,638	0	233,457	24	6	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	394,049	0	1,543,614	1,538,506	15,126	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,802	0	479,745	31,263	2,087	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	543,511	0	91,014	193,951	1,289	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	60,420	0	117,404	0	0	55.00
57.00	05700	CT SCAN	70,218	0	10,054	40,219	652	57.00
58.00	05800	MRI	184,745	0	9,175	55,119	390	58.00
59.00	05900	CARDIAC CATHETERIZATION	77,223	0	159,068	784,542	3,586	59.00
60.00	06000	LABORATORY	250,948	59,025	0	807,666	1,549	60.00
65.00	06500	RESPIRATORY THERAPY	84,522	0	4,309	48,949	42	65.00
66.00	06600	PHYSICAL THERAPY	101,958	59,025	0	174	0	66.00
68.00	06800	SPEECH PATHOLOGY	17,636	0	0	600	0	68.00
69.00	06900	ELECTROCARDIOLOGY	51,519	0	54	682	513	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	69,773	0	0	897	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,379,128	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,579,629	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	5,867,866	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	24,142	0	79,974	340	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	101,575	0	378,344	3,390	2,103	90.01
90.02	09002	WOUND CLINIC	68,862	0	103,748	7,547	589	90.02
91.00	09100	EMERGENCY	306,300	118,049	1,192,250	43,651	2,879	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	44,739	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,935,646	236,099	8,537,895	8,706,094	5,974,622	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	25,650	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	31,232	0	0	0	0	192.00
194.00	07950	HEALTH & FITNESS CENTER	5,348	0	70,466	3,496	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,972,226	236,099	8,634,011	8,709,590	5,974,623	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet B
Part I
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1/26/2022 3:03 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED ED PRGM- (EMS)	
					SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV		
			16.00	17.00	21.00	22.00	23.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	198,171					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	3,063,110			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		878,373		22.00
23.00	02300	PARAMED ED PRGM- (EMS)	0	0			81,223	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,587	0	94,133	878,373	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,316	0	74,430	0	0	31.00
43.00	04300	NURSERY	811	0	4,491	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	28,374	0	203,021	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,952	0	47,697	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,029	0	912,293	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,895	0	167,418	0	0	55.00
57.00	05700	CT SCAN	9,033	0	425,117	0	0	57.00
58.00	05800	MRI	10,254	0	276,487	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,427	0	327,550	0	0	59.00
60.00	06000	LABORATORY	18,403	0	155,628	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,550	0	23,236	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,506	0	23,620	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	316	0	9,438	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,322	0	33,846	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	435	0	92,571	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,680	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,348	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,469	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	118	0	10,304	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	3,210	0	2,377	0	0	90.01
90.02	09002	WOUND CLINIC	1,423	0	2,296	0	0	90.02
91.00	09100	EMERGENCY	15,877	0	50,842	0	81,223	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	836	0	1,203	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	198,171	0	2,937,998	878,373	81,223	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	135	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	99,116	0	0	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	25,861	0	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	198,171	0	3,063,110	878,373	81,223	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet B
Part I
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
23.00	02300	PARAMED ED PRGM- (EMS)				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	75,551,088	-972,506	74,578,582	30.00
31.00	03100	INTENSIVE CARE UNIT	14,885,072	-74,430	14,810,642	31.00
43.00	04300	NURSERY	5,709,070	-4,491	5,704,579	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	47,774,498	-203,021	47,571,477	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,279,227	-47,697	9,231,530	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	31,571,625	-912,293	30,659,332	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,162,680	-167,418	5,995,262	55.00
57.00	05700	CT SCAN	5,482,177	-425,117	5,057,060	57.00
58.00	05800	MRI	7,428,096	-276,487	7,151,609	58.00
59.00	05900	CARDIAC CATHETERIZATION	8,801,518	-327,550	8,473,968	59.00
60.00	06000	LABORATORY	24,720,706	-155,628	24,565,078	60.00
65.00	06500	RESPIRATORY THERAPY	5,233,256	-23,236	5,210,020	65.00
66.00	06600	PHYSICAL THERAPY	4,639,039	-23,620	4,615,419	66.00
68.00	06800	SPEECH PATHOLOGY	1,665,917	-9,438	1,656,479	68.00
69.00	06900	ELECTROCARDIOLOGY	3,548,640	-33,846	3,514,794	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,800,276	-92,571	1,707,705	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,835,699	0	13,835,699	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,552,800	0	17,552,800	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	87,774,106	0	87,774,106	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	4,258,696	-10,304	4,248,392	76.97
OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	7,730,326	-2,377	7,727,949	90.01
90.02	09002	WOUND CLINIC	3,419,682	-2,296	3,417,386	90.02
91.00	09100	EMERGENCY	23,399,673	-50,842	23,348,831	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	3,799,530	-1,203	3,798,327	92.01
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	416,023,397	-3,816,371	412,207,026	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	196,611	-135	196,476	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	12,951,879	-99,116	12,852,763	192.00
194.00	07950	HEALTH & FITNESS CENTER	4,951,387	-25,861	4,925,526	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	194.01
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	434,123,274	-3,941,483	430,181,791	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet B
Part II
Date/Time Prepared:
1/26/2022 3:03 pm

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
5.00	00500	ADMINISTRATIVE & GENERAL	10,473,313	1,813,598	2,081,114	14,368,025	0 5.00
7.00	00700	OPERATION OF PLANT	459,115	12,222,129	403,367	13,084,611	0 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	22,265	0	22,265	0 8.00
9.00	00900	HOUSEKEEPING	0	74,898	40,598	115,496	0 9.00
10.00	01000	DIETARY	0	306,748	0	306,748	0 10.00
11.00	01100	CAFETERIA	0	0	3,471	3,471	0 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	0	59,004	60,957	119,961	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	108,827	135,136	5,443	249,406	0 14.00
15.00	01500	PHARMACY	0	129,484	240,116	369,600	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0 17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0 22.00
23.00	02300	PARAMED ED PRGM-(EMS)	0	0	0	0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	2,703,249	255,564	2,958,813	0 30.00
31.00	03100	INTENSIVE CARE UNIT	0	335,697	202,072	537,769	0 31.00
43.00	04300	NURSERY	0	118,501	12,193	130,694	0 43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0 45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,600	1,822,037	551,191	2,376,828	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	408,929	129,493	538,422	0 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	34,800	301,669	2,476,832	2,813,301	0 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	656,868	454,529	1,111,397	0 55.00
57.00	05700	CT SCAN	0	113,170	1,154,168	1,267,338	0 57.00
58.00	05800	MRI	0	145,703	750,647	896,350	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	220,559	889,279	1,109,838	0 59.00
60.00	06000	LABORATORY	0	198,386	422,522	620,908	0 60.00
65.00	06500	RESPIRATORY THERAPY	0	39,527	63,083	102,610	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	64,127	64,127	0 66.00
68.00	06800	SPEECH PATHOLOGY	0	59,077	25,624	84,701	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	162,755	91,891	254,646	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	75,283	251,324	326,607	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0 74.00
76.97	07697	CARDIAC REHABILITATION	0	322,356	27,975	350,331	0 76.97
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OP PEDS ONC CLINIC	0	241,389	6,454	247,843	0 90.01
90.02	09002	WOUND CLINIC	0	166,282	6,233	172,515	0 90.02
91.00	09100	EMERGENCY	0	698,011	138,032	836,043	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	0 92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	20,387	184,721	3,267	208,375	0 92.01
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,100,042	23,737,431	10,811,566	45,649,039	0 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	366	366	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,576,035	269,094	5,845,129	0 192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	70,210	70,210	0 194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0 194.01
200.00		Cross Foot Adjustments				0	0 200.00
201.00		Negative Cost Centers		0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	11,100,042	29,313,466	11,151,236	51,564,744	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet B
Part II
Date/Time Prepared:
1/26/2022 3:03 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,368,025					5.00
7.00	00700	OPERATION OF PLANT	1,593,191	14,677,802				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	49,302		71,567			8.00
9.00	00900	HOUSEKEEPING	254,067	114,102	37,747	521,412		9.00
10.00	01000	DIETARY	115,717	425,309		8,216	855,990	10.00
11.00	01100	CAFETERIA	134,240			2,191		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	7,438			1,095		12.00
13.00	01300	NURSING ADMINISTRATION	282,151	81,810				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	273,185	190,568		5,477		14.00
15.00	01500	PHARMACY	175,520	179,879		3,286		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				12,049		16.00
17.00	01700	SOCIAL SERVICE						17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	104,464					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	29,731					22.00
23.00	02300	PARAMED ED PRGM-(EMS)	2,770					23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,665,406	3,748,079	20,644	307,808	652,670	30.00
31.00	03100	INTENSIVE CARE UNIT	393,808	465,447	2,285	24,647	71,346	31.00
43.00	04300	NURSERY	159,429	164,302	5,239	7,668		43.00
44.00	04400	SKILLED NURSING FACILITY						44.00
45.00	04500	NURSING FACILITY						45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,192,290	2,553,959	1,290	56,961		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	234,215	566,984	1,557			52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	845,470	1,509,532		13,145		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	144,362	495,976				55.00
57.00	05700	CT SCAN	150,995	156,911				57.00
58.00	05800	MRI	212,784	205,065				58.00
59.00	05900	CARDIAC CATHETERIZATION	220,681	305,806				59.00
60.00	06000	LABORATORY	759,229	281,246		16,431		60.00
65.00	06500	RESPIRATORY THERAPY	164,182	54,805		4,929		65.00
66.00	06600	PHYSICAL THERAPY	148,257		320	6,025		66.00
68.00	06800	SPEECH PATHOLOGY	31,898	220,756				68.00
69.00	06900	ELECTROCARDIOLOGY	92,352	235,253				69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	44,485	104,380				70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	390,385					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	510,429					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,792,089					73.00
74.00	07400	RENAL DIALYSIS						74.00
76.97	07697	CARDIAC REHABILITATION	55,413	790,469	155			76.97
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	196,124	334,687		25,742		90.01
90.02	09002	WOUND CLINIC	83,496	232,468	2,330			90.02
91.00	09100	EMERGENCY	615,311	1,003,891		21,360		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	74,515	256,118			131,974	92.01
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY						101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,199,381	14,677,802	71,567	517,030	855,990	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,368			4,382		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES						192.00
194.00	07950	HEALTH & FITNESS CENTER	165,276					194.00
194.01	07951	OCCUPATIONAL HEALTH						194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		TOTAL (sum lines 118 through 201)	14,368,025	14,677,802	71,567	521,412	855,990	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet B
Part II
Date/Time Prepared:
1/26/2022 3:03 pm

Cost Center Description			CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	139,902					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	8,533				12.00
13.00	01300	NURSING ADMINISTRATION	3,536	0	487,458			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	93	0	0	718,729		14.00
15.00	01500	PHARMACY	7,096	0	0	0	735,381	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	232	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(EMS)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	33,708	0	191,813	14,301	8,909	30.00
31.00	03100	INTENSIVE CARE UNIT	5,738	0	41,681	1,363	439	31.00
43.00	04300	NURSERY	1,431	0	13,180	2	1	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	13,878	0	87,149	126,961	1,862	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	416	0	27,085	2,580	257	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,143	0	5,138	16,005	159	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,128	0	6,628	0	0	55.00
57.00	05700	CT SCAN	2,473	0	568	3,319	80	57.00
58.00	05800	MRI	6,507	0	518	4,549	48	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,720	0	8,981	64,742	441	59.00
60.00	06000	LABORATORY	8,838	2,133	0	66,650	191	60.00
65.00	06500	RESPIRATORY THERAPY	2,977	0	243	4,039	5	65.00
66.00	06600	PHYSICAL THERAPY	3,591	2,133	0	14	0	66.00
68.00	06800	SPEECH PATHOLOGY	621	0	0	49	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,815	0	3	56	63	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,457	0	0	74	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	196,331	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	212,873	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	722,241	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	850	0	4,515	28	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	3,577	0	21,361	280	259	90.01
90.02	09002	WOUND CLINIC	2,425	0	5,857	623	72	90.02
91.00	09100	EMERGENCY	10,788	4,267	67,312	3,602	354	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1,576	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	138,614	8,533	482,032	718,441	735,381	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1,448	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,100	0	0	0	0	192.00
194.00	07950	HEALTH & FITNESS CENTER	188	0	3,978	288	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	139,902	8,533	487,458	718,729	735,381	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED ED PRGM- (EMS)	
					SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV		
			16.00	17.00	21.00	22.00	23.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,049					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	104,464			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		29,963		22.00
23.00	02300	PARAMED ED PRGM- (EMS)	0	0			2,770	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	858	0				30.00
31.00	03100	INTENSIVE CARE UNIT	136	0				31.00
43.00	04300	NURSERY	48	0				43.00
44.00	04400	SKILLED NURSING FACILITY	0	0				44.00
45.00	04500	NURSING FACILITY	0	0				45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,669	0				50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	174	0				52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,061	0				54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	347	0				55.00
57.00	05700	CT SCAN	531	0				57.00
58.00	05800	MRI	603	0				58.00
59.00	05900	CARDIAC CATHETERIZATION	319	0				59.00
60.00	06000	LABORATORY	1,083	0				60.00
65.00	06500	RESPIRATORY THERAPY	150	0				65.00
66.00	06600	PHYSICAL THERAPY	89	0				66.00
68.00	06800	SPEECH PATHOLOGY	19	0				68.00
69.00	06900	ELECTROCARDIOLOGY	313	0				69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	26	0				70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	569	0				71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	373	0				72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,418	0				73.00
74.00	07400	RENAL DIALYSIS	0	0				74.00
76.97	07697	CARDIAC REHABILITATION	7	0				76.97
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	189	0				90.01
90.02	09002	WOUND CLINIC	84	0				90.02
91.00	09100	EMERGENCY	934	0				91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	49	0				92.01
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0				101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,049	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0				192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0				194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0				194.01
200.00		Cross Foot Adjustments			104,464	29,963	2,770	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	12,049	0	104,464	29,963	2,770	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet B
Part II
Date/Time Prepared:
1/26/2022 3:03 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
23.00	02300	PARAMED ED PRGM-(EMS)				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,603,009	0	9,603,009	30.00
31.00	03100	INTENSIVE CARE UNIT	1,544,659	0	1,544,659	31.00
43.00	04300	NURSERY	481,994	0	481,994	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,412,847	0	6,412,847	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,371,690	0	1,371,690	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,222,954	0	5,222,954	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,760,838	0	1,760,838	55.00
57.00	05700	CT SCAN	1,582,215	0	1,582,215	57.00
58.00	05800	MRI	1,326,424	0	1,326,424	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,713,528	0	1,713,528	59.00
60.00	06000	LABORATORY	1,756,709	0	1,756,709	60.00
65.00	06500	RESPIRATORY THERAPY	333,940	0	333,940	65.00
66.00	06600	PHYSICAL THERAPY	224,556	0	224,556	66.00
68.00	06800	SPEECH PATHOLOGY	338,044	0	338,044	68.00
69.00	06900	ELECTROCARDIOLOGY	584,501	0	584,501	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	478,029	0	478,029	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	587,285	0	587,285	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	723,675	0	723,675	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,516,748	0	3,516,748	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	1,201,768	0	1,201,768	76.97
OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	830,062	0	830,062	90.01
90.02	09002	WOUND CLINIC	499,870	0	499,870	90.02
91.00	09100	EMERGENCY	2,563,862	0	2,563,862	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	672,607	0	672,607	92.01
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	45,331,814	0	45,331,814	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,564	0	9,564	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,846,229	0	5,846,229	192.00
194.00	07950	HEALTH & FITNESS CENTER	239,940	0	239,940	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	194.01
200.00		Cross Foot Adjustments	137,197	0	137,197	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	51,564,744	0	51,564,744	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021

Worksheet B-1

Date/Time Prepared:
1/26/2022 3:03 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			BLDG & FIXT (DV SQUARE FEET)	MVBLE EQUIP (ASSIGNED TIME)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	29,315,469					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		11,007,492				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	111,355,779			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,813,721	2,054,287	16,681,935	-128,511,578	292,790,165	5.00
7.00	00700	OPERATION OF PLANT	12,222,969	398,167	4,128,502	0	32,465,743	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	22,267	0	152,625	0	1,004,666	8.00
9.00	00900	HOUSEKEEPING	74,903	40,075	2,348,393	0	5,177,333	9.00
10.00	01000	DIETARY	306,769	0	137,529	0	2,358,050	10.00
11.00	01100	CAFETERIA	0	3,426	0	0	2,735,520	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	151,561	12.00
13.00	01300	NURSING ADMINISTRATION	59,008	60,171	3,970,713	0	5,749,608	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	135,145	5,373	1,592,007	0	5,566,911	14.00
15.00	01500	PHARMACY	129,493	237,021	3,201,784	0	3,576,706	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	1,501,110	0	2,128,756	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	91,727	0	605,853	22.00
23.00	02300	PARAMED ED PRGM-(EMS)	0	0	0	0	56,447	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,703,433	252,270	20,680,697	0	33,937,326	30.00
31.00	03100	INTENSIVE CARE UNIT	335,720	199,467	3,725,369	0	8,024,950	31.00
43.00	04300	NURSERY	118,509	12,036	1,048,034	0	3,248,810	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,822,161	544,086	11,474,645	0	24,296,254	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	408,957	127,824	2,761,546	0	4,772,796	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	301,690	2,444,906	8,452,579	0	17,228,828	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	656,913	448,670	1,309,742	0	2,941,776	55.00
57.00	05700	CT SCAN	113,178	1,139,290	1,002,873	0	3,076,944	57.00
58.00	05800	MRI	145,713	740,971	2,417,367	0	4,336,070	58.00
59.00	05900	CARDIAC CATHETERIZATION	220,574	877,816	1,726,961	0	4,496,998	59.00
60.00	06000	LABORATORY	198,399	417,075	4,337,310	0	15,471,410	60.00
65.00	06500	RESPIRATORY THERAPY	39,530	62,270	1,985,488	0	3,345,667	65.00
66.00	06600	PHYSICAL THERAPY	0	63,300	2,196,269	0	3,021,160	66.00
68.00	06800	SPEECH PATHOLOGY	59,081	25,294	378,807	0	650,014	68.00
69.00	06900	ELECTROCARDIOLOGY	162,766	90,706	1,151,826	0	1,881,935	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	75,288	248,084	364,985	0	906,503	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	7,955,196	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	10,401,428	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	56,897,987	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	322,378	27,614	575,728	0	1,129,195	76.97
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	241,405	6,371	2,245,362	0	3,996,567	90.01
90.02	09002	WOUND CLINIC	166,293	6,153	598,358	0	1,701,458	90.02
91.00	09100	EMERGENCY	698,058	136,253	7,470,770	0	12,538,693	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	184,734	3,225	948,268	0	1,518,455	92.01
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,739,055	10,672,201	110,659,309	-128,511,578	289,353,574	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	361	0	0	68,637	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,576,414	265,625	581,995	-12,821,531	0	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	69,305	114,475	0	3,367,954	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	29,313,466	11,151,236	23,432,766		128,511,578	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.999932	1.013059	0.210432		0.438920	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		14,368,025	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.049073	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021

Worksheet B-1

Date/Time Prepared:
1/26/2022 3:03 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			BLDG & FIXT (DV SQUARE FEET)	MVBLE EQUIP (ASSIGNED TIME)				
			1.00	2.00	4.00	5A	5.00	
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021

Worksheet B-1

Date/Time Prepared:
1/26/2022 3:03 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	258,176				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,164,923			8.00
9.00	00900	HOUSEKEEPING	2,007	614,405	4,352,197		9.00
10.00	01000	DIETARY	7,481	0	68,575	131,304	10.00
11.00	01100	CAFETERIA	0	0	18,287	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	9,143	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,439	0	0	63,399	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,352	0	45,716	1,671	14.00
15.00	01500	PHARMACY	3,164	0	27,430	127,217	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	100,576	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	4,167	22.00
23.00	02300	PARAMED ED PRGM-(EMS)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	65,927	336,037	2,569,258	100,116	30.00
31.00	03100	INTENSIVE CARE UNIT	8,187	37,201	205,724	10,944	31.00
43.00	04300	NURSERY	2,890	85,277	64,003	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	44,923	20,993	475,450	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,973	25,340	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,552	0	109,719	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	8,724	0	0	0	55.00
57.00	05700	CT SCAN	2,760	0	0	0	57.00
58.00	05800	MRI	3,607	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,379	0	0	0	59.00
60.00	06000	LABORATORY	4,947	0	137,149	0	60.00
65.00	06500	RESPIRATORY THERAPY	964	0	41,145	0	65.00
66.00	06600	PHYSICAL THERAPY	0	5,208	50,288	0	66.00
68.00	06800	SPEECH PATHOLOGY	3,883	0	0	11,136	68.00
69.00	06900	ELECTROCARDIOLOGY	4,138	0	0	32,531	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,836	0	0	44,057	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	13,904	2,530	0	15,244	76.97
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OP PEDS ONC CLINIC	5,887	0	214,867	0	90.01
90.02	09002	WOUND CLINIC	4,089	37,932	0	0	90.02
91.00	09100	EMERGENCY	17,658	0	178,294	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	4,505	0	0	20,244	92.01
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	258,176	1,164,923	4,315,624	131,304	2,485,099
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	36,573	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	19,721	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	0	3,377	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	46,715,607	1,445,634	8,575,382	4,881,810	3,972,226
203.00		Unit cost multiplier (Wkst. B, Part I)	180.944809	1.240970	1.970357	37.179446	1.583698
204.00		Cost to be allocated (per Wkst. B, Part II)	14,677,802	71,567	521,412	855,990	139,902
205.00		Unit cost multiplier (Wkst. B, Part II)	56.851923	0.061435	0.119804	6.519146	0.055778
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021

Worksheet B-1

Date/Time Prepared:
1/26/2022 3:03 pm

Cost Center Description			MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
			12.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL	1,012,080					12.00
13.00	01300	NURSING ADMINISTRATION	0	805,496				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	31,541,431			14.00
15.00	01500	PHARMACY	0	0	0	46,579,430		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	2,321,345,442	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (EMS)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	316,957	627,593	564,261	171,613,080	30.00
31.00	03100	INTENSIVE CARE UNIT	0	68,875	59,818	27,824	27,252,553	31.00
43.00	04300	NURSERY	0	21,780	88	44	9,536,037	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	144,009	5,571,633	117,928	333,814,638	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	44,757	113,219	16,273	34,731,255	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,491	702,385	10,051	212,106,741	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	10,953	0	0	69,355,290	55.00
57.00	05700	CT SCAN	0	938	145,652	5,082	106,266,986	57.00
58.00	05800	MRI	0	856	199,612	3,039	120,629,976	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	14,840	2,841,185	27,955	63,843,391	59.00
60.00	06000	LABORATORY	253,020	0	2,924,927	12,080	216,502,413	60.00
65.00	06500	RESPIRATORY THERAPY	0	402	177,268	329	30,001,161	65.00
66.00	06600	PHYSICAL THERAPY	253,020	0	629	3	17,713,557	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	2,172	0	3,720,675	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5	2,470	4,000	62,606,074	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	3,248	0	5,114,240	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	8,615,909	0	113,886,329	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	9,342,042	0	74,683,179	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	45,747,124	395,444,541	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	7,461	1,230	0	1,386,862	76.97
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	0	35,297	12,278	16,398	37,768,207	90.01
90.02	09002	WOUND CLINIC	0	9,679	27,332	4,590	16,744,554	90.02
91.00	09100	EMERGENCY	506,040	111,229	158,082	22,445	186,787,376	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	9,836,327	92.01
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,012,080	796,529	31,528,772	46,579,426	2,321,345,442	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,393	0	4	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	6,574	12,659	0	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	236,099	8,634,011	8,709,590	5,974,623	198,171	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.233281	10.718875	0.276132	0.128267	0.000085	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	8,533	487,458	718,729	735,381	12,049	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.008431	0.605165	0.022787	0.015788	0.000005	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021

Worksheet B-1

Date/Time Prepared:
1/26/2022 3:03 pm

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021

Worksheet B-1

Date/Time Prepared:
1/26/2022 3:03 pm

Cost Center Description			INTERNS & RESIDENTS			PARAMED ED PRGM- (EMS) (ASSIGNED TIME)		
			SOCIAL SERVICE (TIME SPENT)	SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)			
				17.00	21.00			
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	0					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	8,208,972				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		100			22.00
23.00	02300	PARAMED ED PRGM-(EMS)	0			100		23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	252,270	100	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	199,467	0	0		31.00
43.00	04300	NURSERY	0	12,036	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
45.00	04500	NURSING FACILITY	0	0	0	0		45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	544,086	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	127,824	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,444,906	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	448,670	0	0		55.00
57.00	05700	CT SCAN	0	1,139,290	0	0		57.00
58.00	05800	MRI	0	740,971	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	877,816	0	0		59.00
60.00	06000	LABORATORY	0	417,075	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	62,270	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	63,300	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	25,294	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	90,706	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	248,084	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0		74.00
76.97	07697	CARDIAC REHABILITATION	0	27,614	0	0		76.97
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	0	6,371	0	0		90.01
90.02	09002	WOUND CLINIC	0	6,153	0	0		90.02
91.00	09100	EMERGENCY	0	136,253	0	100		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	3,225	0	0		92.01
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	7,873,681	100	100		118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	361	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	265,625	0	0		192.00
194.00	07950	HEALTH & FITNESS CENTER	0	69,305	0	0		194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0		194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	3,063,110	878,373	81,223		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.373142	8,783.730000	812.230000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	104,464	29,963	2,770		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.012726	299.630000	27.700000		205.00

Date/Time Prepared:
1/26/2022 3:03 pm

MCRIF32 - 17.1.172.0

Worksheet C
Part I
Date/Time Prepared:
1/26/2022 3:03 pm

MCRIF32 - 17.1.172.0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet C
Part I
Date/Time Prepared:
1/26/2022 3:03 pm

			Title XVIII		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	136,393,146		136,393,146		30.00
31.00	03100	INTENSIVE CARE UNIT	27,252,553		27,252,553		31.00
43.00	04300	NURSERY	9,536,037		9,536,037		43.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
45.00	04500	NURSING FACILITY	0		0		45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	77,227,433	256,587,205	333,814,638	0.142509	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	32,710,005	2,021,250	34,731,255	0.265799	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,160,278	192,946,463	212,106,741	0.144547	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	1,478,581	67,876,709	69,355,290	0.086443	0.000000
57.00	05700	CT SCAN	36,438,749	69,828,237	106,266,986	0.047588	0.000000
58.00	05800	MRI	17,866,468	102,763,508	120,629,976	0.059286	0.000000
59.00	05900	CARDIAC CATHETERIZATION	30,307,100	33,536,291	63,843,391	0.132731	0.000000
60.00	06000	LABORATORY	84,475,644	132,026,769	216,502,413	0.113463	0.000000
65.00	06500	RESPIRATORY THERAPY	25,185,802	4,815,359	30,001,161	0.173661	0.000000
66.00	06600	PHYSICAL THERAPY	12,929	17,700,628	17,713,557	0.260559	0.000000
68.00	06800	SPEECH PATHOLOGY	1,578,701	2,141,974	3,720,675	0.445209	0.000000
69.00	06900	ELECTROCARDIOLOGY	18,130,223	44,475,851	62,606,074	0.056141	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	644,867	4,469,373	5,114,240	0.333912	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	39,292,770	74,593,559	113,886,329	0.121487	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,167,064	45,516,115	74,683,179	0.235030	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	41,970,338	353,474,203	395,444,541	0.221963	0.000000
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000
76.97	07697	CARDIAC REHABILITATION	1,398	1,385,464	1,386,862	3.063313	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OP PEDS ONC CLINIC	230,776	37,537,431	37,768,207	0.204615	0.000000
90.02	09002	WOUND CLINIC	204,359	16,540,195	16,744,554	0.204089	0.000000
91.00	09100	EMERGENCY	38,327,422	148,459,954	186,787,376	0.125002	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	13,435,707	21,784,227	35,219,934	0.356156	0.000000
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	4,623,650	5,212,677	9,836,327	0.386153	0.000000
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
200.00		Subtotal (see instructions)	685,652,000	1,635,693,442	2,321,345,442		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	685,652,000	1,635,693,442	2,321,345,442		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.142509		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.265799		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.144547		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.086443		55.00
57.00	05700	CT SCAN	0.047588		57.00
58.00	05800	MRI	0.059286		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.132731		59.00
60.00	06000	LABORATORY	0.113463		60.00
65.00	06500	RESPIRATORY THERAPY	0.173661		65.00
66.00	06600	PHYSICAL THERAPY	0.260559		66.00
68.00	06800	SPEECH PATHOLOGY	0.445209		68.00
69.00	06900	ELECTROCARDIOLOGY	0.056141		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.333912		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.121487		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.235030		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.221963		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.97	07697	CARDIAC REHABILITATION	3.063313		76.97
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OP PEDS ONC CLINIC	0.204615		90.01
90.02	09002	WOUND CLINIC	0.204089		90.02
91.00	09100	EMERGENCY	0.125002		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.356156		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.386153		92.01
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY			101.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet C
Part I
Date/Time Prepared:
1/26/2022 3:03 pm

				Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	74,578,582		74,578,582	0	74,578,582	30.00	
31.00	03100	INTENSIVE CARE UNIT	14,810,642		14,810,642	0	14,810,642	31.00	
43.00	04300	NURSERY	5,704,579		5,704,579	0	5,704,579	43.00	
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00	
45.00	04500	NURSING FACILITY	0		0	0	0	45.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	47,571,477		47,571,477	0	47,571,477	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,231,530		9,231,530	0	9,231,530	52.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,659,332		30,659,332	0	30,659,332	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	5,995,262		5,995,262	0	5,995,262	55.00	
57.00	05700	CT SCAN	5,057,060		5,057,060	0	5,057,060	57.00	
58.00	05800	MRI	7,151,609		7,151,609	0	7,151,609	58.00	
59.00	05900	CARDIAC CATHETERIZATION	8,473,968		8,473,968	0	8,473,968	59.00	
60.00	06000	LABORATORY	24,565,078		24,565,078	0	24,565,078	60.00	
65.00	06500	RESPIRATORY THERAPY	5,210,020	0	5,210,020	0	5,210,020	65.00	
66.00	06600	PHYSICAL THERAPY	4,615,419	0	4,615,419	0	4,615,419	66.00	
68.00	06800	SPEECH PATHOLOGY	1,656,479	0	1,656,479	0	1,656,479	68.00	
69.00	06900	ELECTROCARDIOLOGY	3,514,794		3,514,794	0	3,514,794	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	1,707,705		1,707,705	0	1,707,705	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,835,699		13,835,699	0	13,835,699	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,552,800		17,552,800	0	17,552,800	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	87,774,106		87,774,106	0	87,774,106	73.00	
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00	
76.97	07697	CARDIAC REHABILITATION	4,248,392		4,248,392	0	4,248,392	76.97	
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	OP PEDS ONC CLINIC	7,727,949		7,727,949	0	7,727,949	90.01	
90.02	09002	WOUND CLINIC	3,417,386		3,417,386	0	3,417,386	90.02	
91.00	09100	EMERGENCY	23,348,831		23,348,831	0	23,348,831	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	12,543,790		12,543,790	0	12,543,790	92.00	
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	3,798,327		3,798,327	0	3,798,327	92.01	
OTHER REIMBURSABLE COST CENTERS									
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00	
200.00		Subtotal (see instructions)	424,750,816	0	424,750,816	0	424,750,816	200.00	
201.00		Less Observation Beds	12,543,790		12,543,790		12,543,790	201.00	
202.00		Total (see instructions)	412,207,026	0	412,207,026	0	412,207,026	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet C
Part I
Date/Time Prepared:
1/26/2022 3:03 pm

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	136,393,146		136,393,146		30.00
31.00	03100	INTENSIVE CARE UNIT	27,252,553		27,252,553		31.00
43.00	04300	NURSERY	9,536,037		9,536,037		43.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
45.00	04500	NURSING FACILITY	0		0		45.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	77,227,433	256,587,205	333,814,638	0.142509	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	32,710,005	2,021,250	34,731,255	0.265799	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,160,278	192,946,463	212,106,741	0.144547	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	1,478,581	67,876,709	69,355,290	0.086443	0.000000
57.00	05700	CT SCAN	36,438,749	69,828,237	106,266,986	0.047588	0.000000
58.00	05800	MRI	17,866,468	102,763,508	120,629,976	0.059286	0.000000
59.00	05900	CARDIAC CATHETERIZATION	30,307,100	33,536,291	63,843,391	0.132731	0.000000
60.00	06000	LABORATORY	84,475,644	132,026,769	216,502,413	0.113463	0.000000
65.00	06500	RESPIRATORY THERAPY	25,185,802	4,815,359	30,001,161	0.173661	0.000000
66.00	06600	PHYSICAL THERAPY	12,929	17,700,628	17,713,557	0.260559	0.000000
68.00	06800	SPEECH PATHOLOGY	1,578,701	2,141,974	3,720,675	0.445209	0.000000
69.00	06900	ELECTROCARDIOLOGY	18,130,223	44,475,851	62,606,074	0.056141	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	644,867	4,469,373	5,114,240	0.333912	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	39,292,770	74,593,559	113,886,329	0.121487	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,167,064	45,516,115	74,683,179	0.235030	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	41,970,338	353,474,203	395,444,541	0.221963	0.000000
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000
76.97	07697	CARDIAC REHABILITATION	1,398	1,385,464	1,386,862	3.063313	0.000000
	OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	230,776	37,537,431	37,768,207	0.204615	0.000000
90.02	09002	WOUND CLINIC	204,359	16,540,195	16,744,554	0.204089	0.000000
91.00	09100	EMERGENCY	38,327,422	148,459,954	186,787,376	0.125002	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	13,435,707	21,784,227	35,219,934	0.356156	0.000000
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	4,623,650	5,212,677	9,836,327	0.386153	0.000000
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
200.00		Subtotal (see instructions)	685,652,000	1,635,693,442	2,321,345,442		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	685,652,000	1,635,693,442	2,321,345,442		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet C
Part I
Date/Time Prepared:
1/26/2022 3:03 pm

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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS				Provider CCN: 14-0130	Period: From 09/01/2020 To 08/31/2021	Worksheet D Part I Date/Time Prepared: 1/26/2022 3:03 pm		
				Title XVIII	Hospital	PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	9,603,009	0	9,603,009	40,120	239.36	30.00	
31.00	INTENSIVE CARE UNIT	1,544,659		1,544,659	3,649	423.31	31.00	
43.00	NURSERY	481,994		481,994	4,015	120.05	43.00	
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00	
45.00	NURSING FACILITY	0		0	0	0.00	45.00	
200.00	Total (lines 30 through 199)	11,629,662		11,629,662	47,784		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	10,900	2,609,024					30.00
31.00	INTENSIVE CARE UNIT	2,827	1,196,697					31.00
43.00	NURSERY	0	0					43.00
44.00	SKILLED NURSING FACILITY	0	0					44.00
45.00	NURSING FACILITY	0	0					45.00
200.00	Total (lines 30 through 199)	13,727	3,805,721					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet D
Part II
Date/Time Prepared:
1/26/2022 3:03 pm

				Title XVIII		Hospital	PPS		
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,412,847	333,814,638	0.019211	25,806,327	495,765	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,371,690	34,731,255	0.039494	237	9	52.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,222,954	212,106,741	0.024624	8,497,502	209,242	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	1,760,838	69,355,290	0.025389	678,129	17,217	55.00	
57.00	05700	CT SCAN	1,582,215	106,266,986	0.014889	15,609,089	232,404	57.00	
58.00	05800	MRI	1,326,424	120,629,976	0.010996	6,932,580	76,231	58.00	
59.00	05900	CARDIAC CATHETERIZATION	1,713,528	63,843,391	0.026840	12,317,670	330,606	59.00	
60.00	06000	LABORATORY	1,756,709	216,502,413	0.008114	31,055,406	251,984	60.00	
65.00	06500	RESPIRATORY THERAPY	333,940	30,001,161	0.011131	10,542,740	117,351	65.00	
66.00	06600	PHYSICAL THERAPY	224,556	17,713,557	0.012677	11,823	150	66.00	
68.00	06800	SPEECH PATHOLOGY	338,044	3,720,675	0.090856	916,245	83,246	68.00	
69.00	06900	ELECTROCARDIOLOGY	584,501	62,606,074	0.009336	8,339,393	77,857	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	478,029	5,114,240	0.093470	270,339	25,269	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	587,285	113,886,329	0.005157	13,782,830	71,078	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	723,675	74,683,179	0.009690	12,763,887	123,682	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	3,516,748	395,444,541	0.008893	14,660,249	130,374	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00	
76.97	07697	CARDIAC REHABILITATION	1,201,768	1,386,862	0.866538	1,398	1,211	76.97	
	OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	830,062	37,768,207	0.021978	192,752	4,236	90.01	
90.02	09002	WOUND CLINIC	499,870	16,744,554	0.029853	182,939	5,461	90.02	
91.00	09100	EMERGENCY	2,563,862	186,787,376	0.013726	14,785,001	202,939	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,615,189	35,219,934	0.045860	6,175,024	283,187	92.00	
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	672,607	9,836,327	0.068380	1,103,578	75,463	92.01	
200.00		Total (lines 50 through 199)	35,317,341	2,148,163,706		184,625,138	2,814,962	200.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0130		Period: From 09/01/2020 To 08/31/2021		Worksheet D Part III Date/Time Prepared: 1/26/2022 3:03 pm	
					Title XVIII		Hospital		PPS	
Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00	
43.00	04300	NURSERY	0	0	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	44.00	
45.00	04500	NURSING FACILITY	0	0	0	0	0	0	45.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days			
			4.00	5.00	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	40,120	0.00	10,900	30.00		
31.00	03100	INTENSIVE CARE UNIT		0	3,649	0.00	2,827	31.00		
43.00	04300	NURSERY		0	4,015	0.00	0	43.00		
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00		
45.00	04500	NURSING FACILITY		0	0	0.00	0	45.00		
200.00		Total (lines 30 through 199)		0	47,784		13,727	200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)							
			9.00							
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0						30.00	
31.00	03100	INTENSIVE CARE UNIT	0						31.00	
43.00	04300	NURSERY	0						43.00	
44.00	04400	SKILLED NURSING FACILITY	0						44.00	
45.00	04500	NURSING FACILITY	0						45.00	
200.00		Total (lines 30 through 199)	0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet D
Part IV
Date/Time Prepared:
1/26/2022 3:03 pm

Cost Center Description			Title XVIII		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	0	0	0	0	0	90.01
90.02	09002	WOUND CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	81,223	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
200.00		Total (lines 50 through 199)	0	0	0	0	81,223	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet D
Part IV
Date/Time Prepared:
1/26/2022 3:03 pm

				Title XVIII		Hospital	PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	333,814,638	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	34,731,255	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	212,106,741	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	69,355,290	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	106,266,986	0.000000	57.00
58.00	05800	MRI	0	0	0	120,629,976	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	63,843,391	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	216,502,413	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	30,001,161	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	17,713,557	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,720,675	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	62,606,074	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	5,114,240	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	113,886,329	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	74,683,179	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	395,444,541	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,386,862	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	0	0	0	37,768,207	0.000000	90.01
90.02	09002	WOUND CLINIC	0	0	0	16,744,554	0.000000	90.02
91.00	09100	EMERGENCY	0	81,223	81,223	186,787,376	0.000435	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	35,219,934	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	9,836,327	0.000000	92.01
200.00		Total (lines 50 through 199)	0	81,223	81,223	2,148,163,706		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet D
Part IV
Date/Time Prepared:
1/26/2022 3:03 pm

				Title XVIII		Hospital		PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	25,806,327	0	58,705,831	0	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	237	0	0	0	52.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	8,497,502	0	50,245,866	0	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	678,129	0	28,201,290	0	55.00	
57.00	05700	CT SCAN	0.000000	15,609,089	0	19,272,408	0	57.00	
58.00	05800	MRI	0.000000	6,932,580	0	27,884,322	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.000000	12,317,670	0	14,577,020	0	59.00	
60.00	06000	LABORATORY	0.000000	31,055,406	0	22,955,748	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0.000000	10,542,740	0	1,537,533	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	11,823	0	387,657	0	66.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	916,245	0	51,749	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.000000	8,339,393	0	14,289,380	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	270,339	0	1,169,621	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	13,782,830	0	18,967,572	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	12,763,887	0	16,356,653	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	14,660,249	0	152,024,006	0	73.00	
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00	
76.97	07697	CARDIAC REHABILITATION	0.000000	1,398	0	710,380	0	76.97	
	OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	0.000000	192,752	0	13,661,715	0	90.01	
90.02	09002	WOUND CLINIC	0.000000	182,939	0	8,209,614	0	90.02	
91.00	09100	EMERGENCY	0.000435	14,785,001	6,431	19,773,068	8,601	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	6,175,024	0	7,435,101	0	92.00	
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	1,103,578	0	1,165,540	0	92.01	
200.00		Total (lines 50 through 199)		184,625,138	6,431	477,582,074	8,601	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet D
Part V
Date/Time Prepared:
1/26/2022 3:03 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.142509	58,705,831	0	0	8,366,109	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.265799	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.144547	50,245,866	0	0	7,262,889	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.086443	28,201,290	0	0	2,437,804	55.00
57.00	05700	CT SCAN	0.047588	19,272,408	0	0	917,135	57.00
58.00	05800	MRI	0.059286	27,884,322	0	0	1,653,150	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.132731	14,577,020	0	0	1,934,822	59.00
60.00	06000	LABORATORY	0.113463	22,955,748	0	30,460	2,604,628	60.00
65.00	06500	RESPIRATORY THERAPY	0.173661	1,537,533	0	0	267,010	65.00
66.00	06600	PHYSICAL THERAPY	0.260559	387,657	0	0	101,008	66.00
68.00	06800	SPEECH PATHOLOGY	0.445209	51,749	0	0	23,039	68.00
69.00	06900	ELECTROCARDIOLOGY	0.056141	14,289,380	0	0	802,220	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.333912	1,169,621	0	0	390,550	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.121487	18,967,572	0	0	2,304,313	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.235030	16,356,653	0	0	3,844,304	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.221963	152,024,006	0	19,222	33,743,704	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	3.063313	710,380	0	0	2,176,116	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OP PEDS ONC CLINIC	0.204615	13,661,715	0	0	2,795,392	90.01
90.02	09002	WOUND CLINIC	0.204089	8,209,614	0	0	1,675,492	90.02
91.00	09100	EMERGENCY	0.125002	19,773,068	0	0	2,471,673	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.356156	7,435,101	0	0	2,648,056	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.386153	1,165,540	0	0	450,077	92.01
200.00		Subtotal (see instructions)		477,582,074	0	49,682	78,869,491	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		477,582,074	0	49,682	78,869,491	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet D
Part V
Date/Time Prepared:
1/26/2022 3:03 pm

			Title XVIII		Hospital	PPS
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	3,456		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,267		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
	OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OP PEDS ONC CLINIC	0	0		90.01
90.02	09002	WOUND CLINIC	0	0		90.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
200.00		Subtotal (see instructions)	0	7,723		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	7,723		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0130	Period: From 09/01/2020 To 08/31/2021	Worksheet D-1 Date/Time Prepared: 1/26/2022 3:03 pm
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		40,120	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		40,120	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)		33,372	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		10,900	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)		74,578,582	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)		74,578,582	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)		74,578,582	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)		1,858.89	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		20,261,901	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)		20,261,901	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021

Worksheet D-1

Date/Time Prepared:
1/26/2022 3:03 pm

		Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	14,810,642	3,649	4,058.82	2,827	11,474,284
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					26,560,308
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					58,296,493
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					3,805,721
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,821,393
52.00	Total Program excludable cost (sum of lines 50 and 51)					6,627,114
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					51,669,379
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					6,748
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,858.89
89.00	Observation bed cost (line 87 x line 88) (see instructions)					12,543,790

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021

Worksheet D-1

Date/Time Prepared:
1/26/2022 3:03 pm

Cost Center Description		Title XVIII		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	9,603,009	74,578,582	0.128764	12,543,790	1,615,189
91.00	Nursing Program cost	0	74,578,582	0.000000	12,543,790	0
92.00	Allied health cost	0	74,578,582	0.000000	12,543,790	0
93.00	All other Medical Education	0	74,578,582	0.000000	12,543,790	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0130	Period: From 09/01/2020 To 08/31/2021	Worksheet D-1 Date/Time Prepared: 1/26/2022 3:03 pm	
		Title XIX	Hospital	Cost	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		40,120	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		40,120	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)		33,372	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)		795	9.00	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00	
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00	
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00	
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00	
15.00	Total nursery days (title V or XIX only)		4,015	15.00	
16.00	Nursery days (title V or XIX only)		389	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)		74,578,582	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)		74,578,582	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)		74,578,582	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)		1,858.89	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,477,818	39.00	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00	
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,477,818	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021

Worksheet D-1

Date/Time Prepared:
1/26/2022 3:03 pm

		Title XIX		Hospital		Cost	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	5,704,579	4,015	1,420.82	389	552,699	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	14,810,642	3,649	4,058.82	34	138,000	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)						2,168,517 49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						0 54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)						0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0 57.00
58.00	Bonus payment (see instructions)						0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0 61.00
62.00	Relief payment (see instructions)						0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)						6,748 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,858.89 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						12,543,790 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021

Worksheet D-1

Date/Time Prepared:
1/26/2022 3:03 pm

Cost Center Description		Title XIX		Hospital		Cost	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	9,603,009	74,578,582	0.128764	12,543,790	1,615,189	90.00
91.00	Nursing Program cost	0	74,578,582	0.000000	12,543,790	0	91.00
92.00	Allied health cost	0	74,578,582	0.000000	12,543,790	0	92.00
93.00	All other Medical Education	0	74,578,582	0.000000	12,543,790	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0130	Period: From 09/01/2020 To 08/31/2021	Worksheet D-3 Date/Time Prepared: 1/26/2022 3:03 pm	
		Title XVIII	Hospital	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		43,977,775	30.00
31.00	03100	INTENSIVE CARE UNIT		15,400,191	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.142509	25,806,327	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.265799	237	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.144547	8,497,502	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.086443	678,129	55.00
57.00	05700	CT SCAN	0.047588	15,609,089	57.00
58.00	05800	MRI	0.059286	6,932,580	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.132731	12,317,670	59.00
60.00	06000	LABORATORY	0.113463	31,055,406	60.00
65.00	06500	RESPIRATORY THERAPY	0.173661	10,542,740	65.00
66.00	06600	PHYSICAL THERAPY	0.260559	11,823	66.00
68.00	06800	SPEECH PATHOLOGY	0.445209	916,245	68.00
69.00	06900	ELECTROCARDIOLOGY	0.056141	8,339,393	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.333912	270,339	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.121487	13,782,830	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.235030	12,763,887	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.221963	14,660,249	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	74.00
76.97	07697	CARDIAC REHABILITATION	3.063313	1,398	76.97
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OP PEDS ONC CLINIC	0.204615	192,752	90.01
90.02	09002	WOUND CLINIC	0.204089	182,939	90.02
91.00	09100	EMERGENCY	0.125002	14,785,001	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.356156	6,175,024	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.386153	1,103,578	92.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		184,625,138	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)		184,625,138	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0130	Period: From 09/01/2020 To 08/31/2021	Worksheet E Part A Date/Time Prepared: 1/26/2022 3:03 pm	
		Title XVIII	Hospital	PPS	
				1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			2,687,291	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			29,560,200	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)			0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)			0	1.04
2.00	Outlier payments for discharges. (see instructions)				2.00
2.01	Outlier reconciliation amount			0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)			0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)			156,735	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			1,724,083	2.04
3.00	Managed Care Simulated Payments			8,735,839	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			110.87	4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)			22.83	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)			0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)			22.83	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			22.83	10.00
11.00	FTE count for residents in dental and podiatric programs.			0.00	11.00
12.00	Current year allowable FTE (see instructions)			22.83	12.00
13.00	Total allowable FTE count for the prior year.			23.92	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.			24.40	14.00
15.00	Sum of lines 12 through 14 divided by 3.			23.72	15.00
16.00	Adjustment for residents in initial years of the program			0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00	17.00
18.00	Adjusted rolling average FTE count			23.72	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.213944	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.219892	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.213944	21.00
22.00	IME payment adjustment (see instructions)			3,556,028	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			963,327	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C) .			0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)			0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)			0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)			0	28.01
29.00	Total IME payment (sum of lines 22 and 28)			3,556,028	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			963,327	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			2.23	30.00
31.00	Percentage of Medicaid patient days (see instructions)			16.28	31.00
32.00	Sum of lines 30 and 31			18.51	32.00
33.00	Allowable disproportionate share percentage (see instructions)			4.78	33.00
34.00	Disproportionate share adjustment (see instructions)			385,358	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0130	Period: From 09/01/2020 To 08/31/2021	Worksheet E Part A Date/Time Prepared: 1/26/2022 3:03 pm	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	8,350,599,096	0	35.00	
35.01	Factor 3 (see instructions)	0.000245754	0.000000000	35.01	
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	2,052,195	3,183,208	35.02	
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	168,212	2,921,574	35.03	
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	3,089,786		36.00	
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges (see instructions)	0		40.00	
		Before 1/1	On/After 1/1		
		1.00	1.01		
41.00	Total ESRD Medicare discharges (see instructions)	0	0	41.00	
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0	0	41.01	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00	
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00	
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00	
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00	
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00	
47.00	Subtotal (see instructions)	41,159,481		47.00	
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00	
			Amount		
			1.00		
49.00	Total payment for inpatient operating costs (see instructions)	42,122,808	49.00		
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	3,176,387	50.00		
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00		
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	515,058	52.00		
53.00	Nursing and Allied Health Managed Care payment	0	53.00		
54.00	Special add-on payments for new technologies	488,488	54.00		
54.01	Islet isolation add-on payment	0	54.01		
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00		
56.00	Cost of physicians' services in a teaching hospital (see instructions)	0	56.00		
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00		
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	6,431	58.00		
59.00	Total (sum of amounts on lines 49 through 58)	46,309,172	59.00		
60.00	Primary payer payments	0	60.00		
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	46,309,172	61.00		
62.00	Deductibles billed to program beneficiaries	3,368,603	62.00		
63.00	Coinsurance billed to program beneficiaries	50,905	63.00		
64.00	Allowable bad debts (see instructions)	809,581	64.00		
65.00	Adjusted reimbursable bad debts (see instructions)	526,228	65.00		
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	248,815	66.00		
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	43,415,892	67.00		
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00		
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00		
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00		
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)	0	70.50		
70.87	Demonstration payment adjustment amount before sequestration	0	70.87		
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88		
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89		
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90		
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91		
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92		
70.93	HVBP payment adjustment amount (see instructions)	447,379	70.93		
70.94	HRR adjustment amount (see instructions)	-803,929	70.94		
70.95	Recovery of accelerated depreciation	0	70.95		

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0130	Period: From 09/01/2020 To 08/31/2021	Worksheet E Part A Date/Time Prepared: 1/26/2022 3:03 pm	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			454,311	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			42,605,031	71.00
71.01	Sequestration adjustment (see instructions)			0	71.01
71.02	Demonstration payment adjustment amount after sequestration			0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			0	71.03
72.00	Interim payments			42,635,224	72.00
72.01	Interim payments-PARHM			0	72.01
73.00	Tentative settlement (for contractor use only)			0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)			-30,193	74.00
74.01	Balance due provider/program-PARHM (see instructions)			0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			1,560,518	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
1/26/2022 3:03 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,687,291	0	2,687,291		2,687,291
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	29,560,200	0		29,560,200	29,560,200
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	156,735	0	156,735		156,735
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	1,724,083	0		1,724,083	1,724,083
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	8,735,839	0	520,368	8,215,471	8,735,839
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.213944	0.213944	0.213944	0.213944	
6.00	IME payment adjustment (see instructions)	22.00	3,556,028	0	296,336	3,259,692	3,556,028
6.01	IME payment adjustment for managed care (see instructions)	22.01	963,327	0	57,383	905,944	963,327
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	3,556,028	0	296,336	3,259,692	3,556,028
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	963,327	0	57,383	905,944	963,327
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0478	0.0478	0.0478	0.0478	
11.00	Disproportionate share adjustment (see instructions)	34.00	385,358	0	32,113	353,245	385,358
11.01	Uncompensated care payments	36.00	3,089,786	0	28,296	1,031,941	1,060,237
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	41,159,481	0	3,200,771	37,958,710	41,159,481
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	42,122,808	0	3,258,154	38,864,654	42,122,808
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	3,176,387	0	274,412	2,901,975	3,176,387

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
1/26/2022 3:03 pm

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	488,488	0	1,500	136,598	138,098	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	3,534,066	41,903,227	45,437,293	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	2,483,501	0	229,534	2,253,967	2,483,501	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	431,125	0	20,685	410,440	431,125	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0672	0.0672	0.0672	0.0672		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	166,891	0	15,425	151,466	166,891	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0382	0.0382	0.0382	0.0382		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	94,870	0	8,768	86,102	94,870	25.00
26.00	Total prospective capital payments (see instructions)	12.00	3,176,387	0	274,412	2,901,975	3,176,387	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
1/26/2022 3:03 pm

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,687,291	2,687,291		2,687,291	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	29,560,200		29,560,200	29,560,200	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	156,735	156,735		156,735	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	1,724,083		1,724,083	1,724,083	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	8,735,839	727,987	8,007,852	8,735,839	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.213944	0.213944	0.213944		5.00
6.00	IME payment adjustment (see instructions)	22.00	3,556,028	296,336	3,259,692	3,556,028	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	963,327	80,277	883,050	963,327	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	3,556,028	296,336	3,259,692	3,556,028	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	963,327	80,277	883,050	963,327	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0478	0.0478	0.0478		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	385,358	32,113	353,245	385,358	11.00
11.01	Uncompensated care payments	36.00	3,089,786	257,482	2,832,304	3,089,786	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	41,159,481	3,429,957	37,729,524	41,159,481	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	42,122,808	3,510,234	38,612,574	42,122,808	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	3,176,387	72,092	3,104,295	3,176,387	16.00
17.00	Special add-on payments for new technologies	54.00	488,488	40,707	447,781	488,488	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			3,623,033	42,164,650	45,787,683	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
1/26/2022 3:03 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	2,483,501	55,844	2,427,657	2,483,501	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	431,125	10,362	420,763	431,125	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	0.0672	0.0672	0.0672		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	166,891	3,753	163,138	166,891	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0382	0.0382	0.0382		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	94,870	2,133	92,737	94,870	25.00
26.00	Total prospective capital payments (see instructions)	12.00	3,176,387	72,092	3,104,295	3,176,387	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	447,379	37,282	410,097	447,379	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	-803,929	-66,994	-736,935	-803,929	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		35,933	418,378	454,311	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0130	Period: From 09/01/2020 To 08/31/2021	Worksheet E Part B Date/Time Prepared: 1/26/2022 3:03 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		7,723	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		78,860,890	2.00
3.00	OPPS payments		54,553,460	3.00
4.00	Outlier payment (see instructions)		817,700	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		8,601	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		7,723	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		49,682	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)		49,682	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)		49,682	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		41,959	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)		7,723	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)		55,379,761	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		131,543	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		8,516,948	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)		46,738,993	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		696,849	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)		47,435,842	30.00
31.00	Primary payer payments		4,982	31.00
32.00	Subtotal (line 30 minus line 31)		47,430,860	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)		1,016,378	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		660,646	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		254,667	36.00
37.00	Subtotal (see instructions)		48,091,506	37.00
38.00	MSP-LCC reconciliation amount from PS&R		73	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)		48,091,433	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		47,822,020	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)		269,413	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: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet E-1
Part I
Date/Time Prepared:
1/26/2022 3:03 pm

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		41,933,402		46,849,158	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		717,595		976,747	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
3.06			0		0	3.06
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	08/26/2021	15,773	08/26/2021	3,885	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)		-15,773		-3,885	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)		42,635,224		47,822,020	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		269,413	6.01
6.02	SETTLEMENT TO PROGRAM		30,193		0	6.02
7.00	Total Medicare program liability (see instructions)		42,605,031		48,091,433	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet E-1
Part II
Date/Time Prepared:
1/26/2022 3:03 pm

Title XVIII		Hospital	PPS
			1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS			
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8 through 12, and 32.		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 through 12, and 32.		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH			
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet E-3
Part VII
Date/Time Prepared:
1/26/2022 3:03 pm

		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		2,168,517		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		2,168,517	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		2,168,517	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		2,168,517	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		2,168,517	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0130		Period: From 09/01/2020 To 08/31/2021		Worksheet E-4 Date/Time Prepared: 1/26/2022 3:03 pm	
		Title XVIII		Hospital		PPS	
						1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT							
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.					24.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)					0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA					0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)					0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))					0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)					0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)					0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)					24.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)					22.84	6.00
7.00	Enter the lesser of line 5 or line 6					22.84	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.	22.84	0.00	22.84		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.	22.84	0.00	22.84		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	22.84	0.00			11.00	
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	23.92	0.00			12.00	
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	24.40	0.00			13.00	
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	23.72	0.00			14.00	
15.00	Adjustment for residents in initial years of new programs	0.00	0.00			15.00	
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00			15.01	
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00			16.00	
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00			16.01	
17.00	Adjusted rolling average FTE count	23.72	0.00			17.00	
18.00	Per resident amount	109,127.63	0.00			18.00	
19.00	Approved amount for resident costs	2,588,507	0	2,588,507		19.00	
				1.00			
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00		20.00	
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00		21.00	
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00		22.00	
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00		23.00	
24.00	Multiply line 22 time line 23			0		24.00	
25.00	Total direct GME amount (sum of lines 19 and 24)			2,588,507		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) (Title XIX - see S-2 Part IX, line 3.02, column 2)	13,727	1,345	2,690			26.00
27.00	Total Inpatient Days (see instructions)	37,587	37,587	37,587			27.00
28.00	Ratio of inpatient days to total inpatient days	0.365206	0.035784	0.071567			28.00
29.00	Program direct GME amount	945,338	92,627	185,252	1,223,217	29.00	
29.01	Percent reduction for MA DGME		4.07	4.07			29.01
30.00	Reduction for direct GME payments for Medicare Advantage		3,770	7,540	11,310	30.00	
31.00	Net Program direct GME amount				1,211,907	31.00	

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0130	Period: From 09/01/2020 To 08/31/2021	Worksheet E-4 Date/Time Prepared: 1/26/2022 3:03 pm	
		Title XVIII	Hospital	PPS	
			1.00		
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)			58,296,493	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)			58,296,493	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			78,877,214	42.00
43.00	Primary payer payments (see instructions)			4,982	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			78,872,232	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			137,168,725	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.424998	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.575002	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			1,211,907	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			515,058	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			696,849	50.00

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

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021

Worksheet G

Date/Time Prepared:
1/26/2022 3:03 pm

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	759,991	29,978,364	34,114,556	0	1.00
2.00 Temporary investments	0	0	0	0	2.00
3.00 Notes receivable	750,304	0	0	0	3.00
4.00 Accounts receivable	62,351,877	0	0	0	4.00
5.00 Other receivable	713,325	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-20,120,283	0	0	0	6.00
7.00 Inventory	8,154,742	0	0	0	7.00
8.00 Prepaid expenses	817,125	0	0	0	8.00
9.00 Other current assets	9,409,515	0	0	0	9.00
10.00 Due from other funds	41,315,324	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	104,151,920	29,978,364	34,114,556	0	11.00
FIXED ASSETS					
12.00 Land	53,023,598	0	0	0	12.00
13.00 Land improvements	0	0	0	0	13.00
14.00 Accumulated depreciation	0	0	0	0	14.00
15.00 Buildings	589,461,151	0	0	0	15.00
16.00 Accumulated depreciation	-147,387,068	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	125,672,172	0	0	0	19.00
20.00 Accumulated depreciation	-74,527,837	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)	546,242,016	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	79,024,093	2,211,959	558,947	0	31.00
32.00 Deposits on leases	0	0	0	0	32.00
33.00 Due from owners/officers	4	0	0	0	33.00
34.00 Other assets	0	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	79,024,097	2,211,959	558,947	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	729,418,033	32,190,323	34,673,503	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	4,753,388	0	0	0	37.00
38.00 Salaries, wages, and fees payable	13,898,993	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	74,771,991	0	0	0	43.00
44.00 Other current liabilities	19,343,374	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	112,767,746	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	6	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	78,459,817	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	78,459,823	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	191,227,569	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	538,190,464				52.00
53.00 Specific purpose fund		32,190,323			53.00
54.00 Donor created - endowment fund balance - restricted			34,673,503		54.00
55.00 Donor created - endowment fund balance - unrestricted			0		55.00
56.00 Governing body created - endowment fund balance			0		56.00
57.00 Plant fund balance - invested in plant				0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	538,190,464	32,190,323	34,673,503	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	729,418,033	32,190,323	34,673,503	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021

Worksheet G-1

Date/Time Prepared:
1/26/2022 3:03 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		548,442,138		29,978,364		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-21,023,570				2.00
3.00	Total (sum of line 1 and line 2)		527,418,568		29,978,364		3.00
4.00	ASSET RELEA TO FINANCE PROP AND EQUI	1,361,892		0		0	4.00
5.00	OTHER	0		1,813		0	5.00
6.00	RECLASSIFICATIONS	0		166,208		0	6.00
7.00	GIFTS AND OTHER REVENUE	1		6,137,652		558,947	7.00
8.00	POSTRETIREMENT BENEFIT TO COST	37,706,876		0		0	8.00
9.00	INVESTMENT INCOM & CHG IN NET ASSETS	0		3,275,171		0	9.00
10.00	Total additions (sum of line 4-9)		39,068,769		9,580,844		10.00
11.00	Subtotal (line 3 plus line 10)		566,487,337		39,559,208		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	OPERATING EXPENSES	0		5,940,593		0	13.00
14.00	PROPERTY ADDITIONS	0		1,361,892		0	14.00
15.00	RECLASSIFICATION	0		0		0	15.00
16.00	OTHER	1		66,400		0	16.00
17.00	POST BENE TO RELATED TO NET PENSION	28,296,872		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		28,296,873		7,368,885		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		538,190,464		32,190,323		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	34,114,556		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)	34,114,556		0			3.00
4.00	ASSET RELEA TO FINANCE PROP AND EQUI		0				4.00
5.00	OTHER		0				5.00
6.00	RECLASSIFICATIONS		0				6.00
7.00	GIFTS AND OTHER REVENUE		0				7.00
8.00	POSTRETIREMENT BENEFIT TO COST		0				8.00
9.00	INVESTMENT INCOM & CHG IN NET ASSETS		0				9.00
10.00	Total additions (sum of line 4-9)	558,947		0			10.00
11.00	Subtotal (line 3 plus line 10)	34,673,503		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00	OPERATING EXPENSES		0				13.00
14.00	PROPERTY ADDITIONS		0				14.00
15.00	RECLASSIFICATION		0				15.00
16.00	OTHER		0				16.00
17.00	POST BENE TO RELATED TO NET PENSION		0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	34,673,503		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
1/26/2022 3:03 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	131,196,554		131,196,554	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	131,196,554		131,196,554	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	19,794,467		19,794,467	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)	19,794,467		19,794,467	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	150,991,021		150,991,021	17.00
18.00	Ancillary services	521,166,639	0	521,166,639	18.00
19.00	Outpatient services	0	1,648,564,509	1,648,564,509	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	672,157,660	1,648,564,509	2,320,722,169	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		481,780,233		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	BAD DEBT	0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		481,780,233		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0130

Period:
From 09/01/2020
To 08/31/2021

Worksheet G-3

Date/Time Prepared:
1/26/2022 3:03 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	2,320,722,169	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,902,352,768	2.00
3.00	Net patient revenues (line 1 minus line 2)	418,369,401	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	481,780,233	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-63,410,832	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	2,596,050	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	1,399,234	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.)	81,009	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	520	21.00
22.00	Rental of hospital space	8,389,690	22.00
23.00	Governmental appropriations	-2,504	23.00
24.00	NET ASSETS AND HAP REVENUE	22,028,467	24.00
24.01	OTHER INCOME	4,183,567	24.01
24.50	COVID-19 PHE Funding	3,711,229	24.50
25.00	Total other income (sum of lines 6-24)	42,387,262	25.00
26.00	Total (line 5 plus line 25)	-21,023,570	26.00
27.00	OTHER	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-21,023,570	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0130	Period: From 09/01/2020 To 08/31/2021	Worksheet L Parts I-III Date/Time Prepared: 1/26/2022 3:03 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		2,483,501	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		431,125	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		102.98	3.00
4.00	Number of interns & residents (see instructions)		23.72	4.00
5.00	Indirect medical education percentage (see instructions)		6.72	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		166,891	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		2.23	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		16.28	8.00
9.00	Sum of lines 7 and 8		18.51	9.00
10.00	Allowable disproportionate share percentage (see instructions)		3.82	10.00
11.00	Disproportionate share adjustment (see instructions)		94,870	11.00
12.00	Total prospective capital payments (see instructions)		3,176,387	12.00
1.00				
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
1.00				
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00