

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-3027	Period: From 09/01/2020 To 08/31/2021	Worksheet S Parts I-III Date/Time Prepared: 1/25/2022 7:35 pm
--	-----------------------	---	--

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

PART II - CERTIFICATION 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 MARIANJOY REHAB HOSPITAL & CLINIC (14-3027) 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	-218,553	629	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing Bed - SNF	0	0	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00 Total	0	-218,553	629	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-3027		Period: From 09/01/2020 To 08/31/2021		Worksheet S-2 Part I Date/Time Prepared: 1/25/2022 7:35 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 26W171 ROOSEVELT ROAD			PO Box:				1.00	
2.00	City: WHEATON			State: IL		Zip Code: 60187		County: DUPAGE 2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
								8.00	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			MARIANJOY REHAB HOSPITAL & CLINIC	143027	16974	5	01/01/1973	N P P 3.00
4.00	Subprovider - IPF								4.00
5.00	Subprovider - IRF								5.00
6.00	Subprovider - (Other)								6.00
7.00	Swing Beds - SNF								7.00
8.00	Swing Beds - NF								8.00
9.00	Hospital-Based SNF								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.					N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised 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:
1/25/2022 7:35 pm

MCRIF32 - 17.1.172.0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-3027		Period: From 09/01/2020 To 08/31/2021		Worksheet S-2 Part I Date/Time Prepared: 1/25/2022 7:35 pm	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		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)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00
						0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet S-2
Part I
Date/Time Prepared:
1/25/2022 7:35 pm

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
	1.00	2.00	3.00	4.00	5.00			
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
			1.00	2.00	3.00			
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
			1.00	2.00	5.00			
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00		
			1.00	2.00	3.00			
70.00	Inpatient Psychiatric Facility PPS							
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00		
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00	
	Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				Y	75.00		
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				Y	N	0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-3027	Period: From 09/01/2020 To 08/31/2021	Worksheet S-2 Part I Date/Time Prepared: 1/25/2022 7:35 pm	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N	N
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-3027	Period: From 09/01/2020 To 08/31/2021	Worksheet S-2 Part I Date/Time Prepared: 1/25/2022 7:35 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
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:	61,188	190,409	1,221,522118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0640	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-3027		Period: From 09/01/2020 To 08/31/2021		Worksheet S-2 Part I Date/Time Prepared: 1/25/2022 7:35 pm		
1.00		2.00		3.00						
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.										
141.00	Name: NORTHWESTERN MEMORIAL HEALTHCARE		Contractor's Name: NGS		Contractor's Number: 00450				141.00	
142.00	Street: 251 E HURON STREET		PO Box:						142.00	
143.00	City: CHICAGO		State: IL		Zip Code: 60611				143.00	
								1.00		
144.00	Are provider based physicians' costs included in Worksheet A?								Y	144.00
								1.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				Y		N		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N				146.00	
								1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital			N	N	N	N		155.00	
156.00	Subprovider - IPF			N	N	N	N		156.00	
157.00	Subprovider - IRF			N	N	N	N		157.00	
158.00	SUBPROVIDER								158.00	
159.00	SNF			N	N	N	N		159.00	
160.00	HOME HEALTH AGENCY			N	N	N	N		160.00	
161.00	CMHC				N	N	N		161.00	
								1.00		
Multicampus										
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00
				Name	County	State	Zip Code	CBSA	FTE/Campus	
				0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00	
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)									168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								0.00	169.00
						Beginning	Ending			
						1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00	
						1.00	2.00			
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N		0	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-3027	Period: From 09/01/2020 To 08/31/2021	Worksheet S-2 Part II Date/Time Prepared: 1/25/2022 7:35 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for 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.	N		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.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		Y	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N
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	12/09/2021	Y
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet S-2
Part II
Date/Time Prepared:
1/25/2022 7:35 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BRANDON	HOFMANN		41.00
42.00	Enter the employer/company name of the cost report preparer.	NORTHWESTERN MEMORIAL HEALTHCARE			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	815-766-7529	BRANDON.HOMFANN@NM.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet S-2
Part II
Date/Time Prepared:
1/25/2022 7:35 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.	PROGRAM 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: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet S-3
Part I
Date/Time Prepared:
1/25/2022 7:35 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	125	45,625	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		125	45,625	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		125	45,625	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						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		125			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet S-3
Part I
Date/Time Prepared:
1/25/2022 7:35 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)	20,236	3,068	42,917			1.00
2.00	HMO and other (see instructions)	6,726	2,851				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)	20,236	3,068	42,917			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)	20,236	3,068	42,917	18.70	502.70	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						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				18.70	502.70	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet S-3
Part I
Date/Time Prepared:
1/25/2022 7:35 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,456	195	2,795	1.00
2.00 HMO and other (see instructions)			442	182		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,456	195	2,795	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-3027

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

Worksheet A

Date/Time Prepared:
1/25/2022 7:35 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		4,027,707	4,027,707	-809,679	3,218,028	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	761,309	761,309	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	405,205	86,918	492,123	9,995,867	10,487,990	4.00
5.01	00590	A&G NON INTERN & NON RESIDENT	2,794,973	5,440,894	8,235,867	-1,204,033	7,031,834	5.01
5.02	00560	A&G PURCHASING & RECEIVING	187,424	134,471	321,895	-41,170	280,725	5.02
5.03	00570	A&G ADMITTING	1,509,657	387,497	1,897,154	-366,820	1,530,334	5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE	0	0	0	0	0	5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED	2,705,811	19,732,788	22,438,599	-1,329,232	21,109,367	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	167	5,115,675	5,115,842	-233,321	4,882,521	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	917,433	926,013	1,843,446	-409,238	1,434,208	9.00
10.00	01000	DIETARY	1,448,618	1,860,816	3,309,434	-1,427,524	1,881,910	10.00
11.00	01100	CAFETERIA	0	0	0	850,350	850,350	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	601,757	183,808	785,565	-139,232	646,333	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	393,565	449,976	843,541	-136,416	707,125	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	990,231	990,231	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	25,647	10,208	35,855	-10,208	25,647	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,395,537	663,704	2,059,241	-360,740	1,698,501	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,402,648	6,052,188	21,454,836	-4,396,568	17,058,268	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	71,918	102,143	174,061	116,955	291,016	54.00
60.00	06000	LABORATORY	0	309,278	309,278	533,632	842,910	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	249,860	98,524	348,384	-73,027	275,357	65.00
66.00	06600	PHYSICAL THERAPY	2,867,444	792,020	3,659,464	-727,383	2,932,081	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,027,112	523,361	2,550,473	-499,983	2,050,490	67.00
68.00	06800	SPEECH PATHOLOGY	1,634,557	387,767	2,022,324	-355,358	1,666,966	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	51,535	51,535	6,858	58,393	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,211,736	1,009,074	2,220,810	-247,702	1,973,108	73.00
74.00	07400	RENAL DIALYSIS	0	282,743	282,743	0	282,743	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	2,240,927	700,003	2,940,930	-467,588	2,473,342	90.01
90.02	09002	OTHER DAY HOSPITAL	75	6,267	6,342	-17	6,325	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	38,092,071	49,335,378	87,427,449	19,963	87,447,412	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	574	573	1,147	-22	1,125	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	81,292	117,532	198,824	-19,941	178,883	191.01
200.00		TOTAL (SUM OF LINES 118 through 199)	38,173,937	49,453,483	87,627,420	0	87,627,420	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet A
Date/Time Prepared:
1/25/2022 7:35 pm

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-330,384	2,887,644	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	83,553	844,862	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,599,340	7,888,650	4.00
5.01	00590	A&G NON INTERN & NON RESIDENT	-3,313,218	3,718,616	5.01
5.02	00560	A&G PURCHASING & RECEIVING	-290	280,435	5.02
5.03	00570	A&G ADMITTING	-70	1,530,264	5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE	0	0	5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED	-8,556,904	12,552,463	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-425,771	4,456,750	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	8.00
9.00	00900	HOUSEKEEPING	-2,382	1,431,826	9.00
10.00	01000	DIETARY	114,267	1,996,177	10.00
11.00	01100	CAFETERIA	-452,433	397,917	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	-10,162	636,171	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-1,645	705,480	14.00
15.00	01500	PHARMACY	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	990,231	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	25,647	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	-671,788	1,026,713	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-159,876	16,898,392	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,692	289,324	54.00
60.00	06000	LABORATORY	-41	842,869	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	-10	275,347	65.00
66.00	06600	PHYSICAL THERAPY	-71,241	2,860,840	66.00
67.00	06700	OCCUPATIONAL THERAPY	-299	2,050,191	67.00
68.00	06800	SPEECH PATHOLOGY	-2,985	1,663,981	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	58,393	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-1,181	1,971,927	73.00
74.00	07400	RENAL DIALYSIS	0	282,743	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	WHEATON OUTPATIENT	-157,267	2,316,075	90.01
90.02	09002	OTHER DAY HOSPITAL	0	6,325	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-16,561,159	70,886,253	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	1,125	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	178,883	191.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-16,561,159	71,066,261	200.00

RECLASSIFICATIONS

Provider CCN: 14-3027

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

Worksheet A-6

Date/Time Prepared:
1/25/2022 7:35 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	451,923	398,427		1.00
	TOTALS		451,923	398,427		
	B - MEDICAL SUPPLIES CHARGED TO PATIENTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	6,858		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
	TOTALS		0	6,858		
	C - PATIENT SCHEDULING					
1.00	ADULTS & PEDIATRICS	30.00	584,064	3,495		1.00
2.00	PHYSICAL THERAPY	66.00	1,728	10		2.00
3.00	OCCUPATIONAL THERAPY	67.00	32	0		3.00
4.00	SPEECH PATHOLOGY	68.00	282	2		4.00
5.00	WHEATON OUTPATIENT	90.01	53,278	319		5.00
	TOTALS		639,384	3,826		
	D - STAFF RECLASS					
1.00	SOCIAL SERVICE	17.00	990,231	0		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		990,231	0		
	E - CROSS DEPARTMENT RECLASS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	136,080	0		1.00
2.00	LABORATORY	60.00	533,632	0		2.00
	TOTALS		669,712	0		
	F - RENTED SPACE RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	357,648		1.00
2.00	A&G NON INTERN & NON RESIDENT	5.01	0	7,166		2.00
3.00	A&G OTHER INTERN & RESIDENT RELATED	5.05	0	83,930		3.00
4.00	OPERATION OF PLANT	7.00	0	124,379		4.00
5.00	HOUSEKEEPING	9.00	0	1,114		5.00
6.00	DIETARY	10.00	0	6,503		6.00
7.00	NURSING ADMINISTRATION	13.00	0	6,018		7.00
8.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	5,143		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	28,279		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,630		10.00
11.00	PHYSICAL THERAPY	66.00	0	44,931		11.00
12.00	OCCUPATIONAL THERAPY	67.00	0	678		12.00
13.00	SPEECH PATHOLOGY	68.00	0	969		13.00
14.00	WHEATON OUTPATIENT	90.01	0	94,278		14.00
	TOTALS		0	763,666		
	G - BENEFITS RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	9,995,867		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
	TOTALS		0	9,995,867		
	H - DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	761,309		1.00
	TOTALS		0	761,309		
500.00	Grand Total: Increases		2,751,250	11,929,953		500.00

RECLASSIFICATIONS

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet A-6
Date/Time Prepared:
1/25/2022 7:35 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	451,923	398,427	0		1.00
	TOTALS		451,923	398,427			
	B - MEDICAL SUPPLIES CHARGED TO PATIENTS						
1.00	A&G OTHER INTERN & RESIDENT RELATED	5.05	0	7	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	20	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	6,826	0		3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0	5	0		4.00
	TOTALS		0	6,858			
	C - PATIENT SCHEDULING						
1.00	A&G NON INTERN & NON RESIDENT	5.01	639,384	3,826	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	TOTALS		639,384	3,826			
	D - STAFF RECLASS						
1.00	A&G OTHER INTERN & RESIDENT RELATED	5.05	863,984	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	38,299	0	0		2.00
3.00	WHEATON OUTPATIENT	90.01	87,948	0	0		3.00
	TOTALS		990,231	0			
	E - CROSS DEPARTMENT RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	669,712	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		669,712	0			
	F - RENTED SPACE RECLASS						
1.00	OPERATION OF PLANT	7.00	0	357,648	10		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	406,018	10		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
	TOTALS		0	763,666			
	G - BENEFITS RECLASS						
1.00	A&G NON INTERN & NON RESIDENT	5.01	0	567,989	0		1.00
2.00	A&G PURCHASING & RECEIVING	5.02	0	41,170	0		2.00
3.00	A&G ADMITTING	5.03	0	366,820	0		3.00
4.00	A&G OTHER INTERN & RESIDENT RELATED	5.05	0	549,171	0		4.00
5.00	OPERATION OF PLANT	7.00	0	52	0		5.00
6.00	HOUSEKEEPING	9.00	0	410,352	0		6.00
7.00	DIETARY	10.00	0	583,677	0		7.00
8.00	NURSING ADMINISTRATION	13.00	0	145,250	0		8.00
9.00	CENTRAL SERVICES & SUPPLY	14.00	0	136,416	0		9.00
10.00	OTHER GENERAL SERVICE (SPECIFY)	18.00	0	10,208	0		10.00
11.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	365,883	0		11.00
12.00	ADULTS & PEDIATRICS	30.00	0	4,304,375	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	21,755	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	66,201	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	774,052	0		15.00
16.00	OCCUPATIONAL THERAPY	67.00	0	500,693	0		16.00
17.00	SPEECH PATHOLOGY	68.00	0	356,611	0		17.00
18.00	DRUGS CHARGED TO PATIENTS	73.00	0	247,697	0		18.00
19.00	WHEATON OUTPATIENT	90.01	0	527,515	0		19.00
20.00	OTHER DAY HOSPITAL	90.02	0	17	0		20.00
21.00	RESEARCH	191.00	0	22	0		21.00
22.00	CONTRACT MNGMT & JOINT VENTURE	191.01	0	19,941	0		22.00
	TOTALS		0	9,995,867			

RECLASSIFICATIONS

Provider CCN: 14-3027

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

Worksheet A-6

Date/Time Prepared:
1/25/2022 7:35 pm

	Decreases				wkst. A-7 Ref.		
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00	10.00		
1.00	H - DEPRECIATION						
	CAP REL COSTS-BLDG & FIXT	1.00	0	761,309	9		1.00
	TOTALS		0	761,309			
500.00	Grand Total: Decreases			2,751,250	11,929,953		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet A-7
Part I
Date/Time Prepared:
1/25/2022 7:35 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	6,800,000	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	71,703,622	1,488,434	0	1,488,434	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	8,035,219	805,310	0	805,310	30,371	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	86,538,841	2,293,744	0	2,293,744	30,371	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	86,538,841	2,293,744	0	2,293,744	30,371	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	6,800,000	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	73,192,056	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	8,810,158	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	88,802,214	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	88,802,214	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet A-7
Part II
Date/Time Prepared:
1/25/2022 7:35 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	4,027,707	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,027,707	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	4,027,707				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	4,027,707				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet A-7
Part III
Date/Time Prepared:
1/25/2022 7:35 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	73,192,056	0	73,192,056	0.892562	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8,810,158	0	8,810,158	0.107438	0	2.00
3.00	Total (sum of lines 1-2)	82,002,214	0	82,002,214	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,936,014	-48,370	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	844,862	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,780,876	-48,370	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	2,887,644	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	844,862	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	3,732,506	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-3027

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

Worksheet A-8

Date/Time Prepared:
1/25/2022 7:35 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	-292,052			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	-10,726,047			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-452,433	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	0	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-3027

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

Worksheet A-8

Date/Time Prepared:
1/25/2022 7:35 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
			3.00	4.00	5.00	
33.00 OTHER OPERATING REVENUE	B	-29,242	A&G OTHER INTERN & RESIDENT RELATED	5.05	0	33.00
33.01 OTHER OPERATING REVENUE	B	-425,616	OPERATION OF PLANT	7.00	0	33.01
33.02 OTHER OPERATING REVENUE	B	-435,864	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	33.02
33.03 OTHER OPERATING REVENUE	B	-1,692	RADIOLOGY-DIAGNOSTIC	54.00	0	33.03
33.04 OTHER OPERATING REVENUE	B	-41	LABORATORY	60.00	0	33.04
33.05 OTHER OPERATING REVENUE	B	-70,627	PHYSICAL THERAPY	66.00	0	33.05
33.06 OTHER OPERATING REVENUE	B	-154,077	WHEATON OUTPATIENT	90.01	0	33.06
33.07 OTHER OPERATING REVENUE	B	0	OTHER DAY HOSPITAL	90.02	0	33.07
33.08 IDPA ASSESSMENTS	A	-3,097,574	A&G NON INTERN & NON RESIDENT	5.01	0	33.08
34.00 TRANSPORTATION EXPENSE	A	-202,675	A&G NON INTERN & NON RESIDENT	5.01	0	34.00
34.01 FUNDRAISING	A	-59	A&G NON INTERN & NON RESIDENT	5.01	0	34.01
34.02 LOBBYING	A	-9,646	A&G NON INTERN & NON RESIDENT	5.01	0	34.02
34.03 MEMBERSHIP DUES	A	-825	A&G NON INTERN & NON RESIDENT	5.01	0	34.03
34.04 MEMBERSHIP DUES	A	-3,144	A&G OTHER INTERN & RESIDENT RELATED	5.05	0	34.04
34.05 MEMBERSHIP DUES	A	-234	A&G NON INTERN & NON RESIDENT	5.01	0	34.05
34.06 MEMBERSHIP DUES	A	-24,951	A&G OTHER INTERN & RESIDENT RELATED	5.05	0	34.06
34.07 MEMBERSHIP DUES	A	-2,781	A&G OTHER INTERN & RESIDENT RELATED	5.05	0	34.07
34.08 MEMBERSHIP DUES	A	-8,281	NURSING ADMINISTRATION	13.00	0	34.08
34.09 MEMBERSHIP DUES	A	-165	CENTRAL SERVICES & SUPPLY	14.00	0	34.09
34.10 MEMBERSHIP DUES	A	-18,096	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	34.10
34.11 MEMBERSHIP DUES	A	500	DRUGS CHARGED TO PATIENTS	73.00	0	34.11
34.12 MEMBERSHIP DUES	A	-516	WHEATON OUTPATIENT	90.01	0	34.12
34.13 SPECIAL PURPOSE FUND/FOUNDATION	A	-197,258	A&G OTHER INTERN & RESIDENT RELATED	5.05	0	34.13
34.14 DISPOSAL WRITE OFF	A	3,700	CAP REL COSTS-BLDG & FIXT	1.00	9	34.14
34.15 REAL ESTATE TAXES	A	-4,714	A&G OTHER INTERN & RESIDENT RELATED	5.05	0	34.15
34.16 SCHOLARSHIPS	A	-75,000	A&G OTHER INTERN & RESIDENT RELATED	5.05	0	34.16
34.17 MISC EXPENSE	A	-1,673	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.17
34.18 MISC EXPENSE	A	-1,543	A&G NON INTERN & NON RESIDENT	5.01	0	34.18
34.19 MISC EXPENSE	A	-46,606	A&G OTHER INTERN & RESIDENT RELATED	5.05	0	34.19
34.20 MISC EXPENSE	A	-978	CENTRAL SERVICES & SUPPLY	14.00	0	34.20
34.21 MISC EXPENSE	A	-7,842	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	34.21
34.22 MISC EXPENSE	A	-210	ADULTS & PEDIATRICS	30.00	0	34.22
34.23 MISC EXPENSE	A	-27	OCCUPATIONAL THERAPY	67.00	0	34.23
34.24 MISC EXPENSE	A	-81	SPEECH PATHOLOGY	68.00	0	34.24
34.25 MISC EXPENSE	A	-1,117	DRUGS CHARGED TO PATIENTS	73.00	0	34.25
34.26 MISC EXPENSE	A	-601	WHEATON OUTPATIENT	90.01	0	34.26
34.27 MARKETING	A	-7,789	A&G OTHER INTERN & RESIDENT RELATED	5.05	0	34.27
34.28 MARKETING	A	-54	ADULTS & PEDIATRICS	30.00	0	34.28
34.29 SERVICE RECOGNITION	A	-2,382	HOUSEKEEPING	9.00	0	34.29
34.30 SERVICE RECOGNITION	A	-1,035	DIETARY	10.00	0	34.30
34.31 SERVICE RECOGNITION	A	-601	NURSING ADMINISTRATION	13.00	0	34.31
34.32 TRAVEL EXPENSE	A	-28	A&G OTHER INTERN & RESIDENT RELATED	5.05	0	34.32
34.33 TRAVEL EXPENSE	A	-502	CENTRAL SERVICES & SUPPLY	14.00	0	34.33
34.34 TRAVEL EXPENSE	A	-235	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	34.34
34.35 TRAVEL EXPENSE	A	-1,324	WHEATON OUTPATIENT	90.01	0	34.35
34.36 MEETINGS LUNCHEONS BANQUESTS	A	-662	A&G NON INTERN & NON RESIDENT	5.01	0	34.36
34.37 MEETINGS LUNCHEONS BANQUESTS	A	-290	A&G PURCHASING & RECEIVING	5.02	0	34.37
34.38 MEETINGS LUNCHEONS BANQUESTS	A	-70	A&G ADMITTING	5.03	0	34.38

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-3027

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

Worksheet A-8

Date/Time Prepared:
1/25/2022 7:35 pm

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
34.39 MEETINGS LUNCHEONS BANQUESTS	A	-37,011	A&G OTHER INTERN & RESIDENT RELATED	5.05	0	34.39
34.40 MEETINGS LUNCHEONS BANQUESTS	A	-114	OPERATION OF PLANT	7.00	0	34.40
34.41 MEETINGS LUNCHEONS BANQUESTS	A	115,302	DIETARY	10.00	0	34.41
34.42 MEETINGS LUNCHEONS BANQUESTS	A	-1,280	NURSING ADMINISTRATION	13.00	0	34.42
34.43 MEETINGS LUNCHEONS BANQUESTS	A	-18,409	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	34.43
34.44 MEETINGS LUNCHEONS BANQUESTS	A	-58,902	ADULTS & PEDIATRICS	30.00	0	34.44
34.45 MEETINGS LUNCHEONS BANQUESTS	A	-10	RESPIRATORY THERAPY	65.00	0	34.45
34.46 MEETINGS LUNCHEONS BANQUESTS	A	-614	PHYSICAL THERAPY	66.00	0	34.46
34.47 MEETINGS LUNCHEONS BANQUESTS	A	-272	OCCUPATIONAL THERAPY	67.00	0	34.47
34.48 MEETINGS LUNCHEONS BANQUESTS	A	-2,904	SPEECH PATHOLOGY	68.00	0	34.48
34.49 MEETINGS LUNCHEONS BANQUESTS	A	-564	DRUGS CHARGED TO PATIENTS	73.00	0	34.49
34.50 MEETINGS LUNCHEONS BANQUESTS	A	-749	WHEATON OUTPATIENT	90.01	0	34.50
34.51 PROVISION FOR BAD DEBT	A	-41	OPERATION OF PLANT	7.00	0	34.51
35.00 MEDICARE DEPRECIATION	A	-334,084	CAP REL COSTS-BLDG & FIXT	1.00	9	35.00
36.00 MEDICARE DEPRECIATION	A	83,553	CAP REL COSTS-MVBLE EQUIP	2.00	9	36.00
37.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	37.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-16,561,159				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-3027

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

Worksheet A-8-1

Date/Time Prepared:
1/25/2022 7:35 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		4.00	EMPLOYEE BENEFITS DEPARTMENT	NMHC HOME OFFICE	4,742,996	7,340,663 1.00
2.00		5.05	A&G OTHER INTERN & RESIDENT	NMHC HOME OFFICE	9,727,562	17,187,592 2.00
3.00		5.01	A&G NON INTERN & NON RESIDENT	INSURANCE	963,950	963,950 3.00
4.00		5.05	A&G OTHER INTERN & RESIDENT	PURCHASED SERVICE	228,081	228,081 4.00
4.01		5.05	A&G OTHER INTERN & RESIDENT	PURCHASED SERVICE	0	668,350 4.01
4.02		21.00	I&R SERVICES-SALARY & FRINGE	PHYSICIAN SERVICES	191,342	191,342 4.02
4.03		30.00	ADULTS & PEDIATRICS	PHYSICIAN SERVICES	100,710	100,710 4.03
4.04		60.00	LABORATORY	CORPORATE EXPENSE	304,333	304,333 4.04
4.05		60.00	LABORATORY	CORPORATE EXPENSE	341	341 4.05
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				16,259,315	26,985,362 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	NMHC	100.00	NMHC	100.00	6.00
7.00	B	NMHC	100.00	NMHC	100.00	7.00
8.00	B	CDH	100.00	CDH	100.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-3027

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

Worksheet A-8-1

Date/Time Prepared:
1/25/2022 7:35 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	-2,597,667	0		1.00
2.00	-7,460,030	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
4.01	-668,350	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
5.00	-10,726,047			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-3027

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

Worksheet A-8-2

Date/Time Prepared:
1/25/2022 7:35 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	21.00	I&R SERVICES-SALARY & FRINGES APPRV	191,342	191,342	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	100,710	100,710	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			292,052	292,052	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	21.00	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	21.00	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	191,342		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	100,710		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	292,052		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet B
Part I
Date/Time Prepared:
1/25/2022 7:35 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	A&G NON INTERN & NON RESIDENT	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	5.01
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,887,644	2,887,644			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	844,862		844,862		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,888,650	0	0	7,888,650	4.00
5.01	00590	A&G NON INTERN & NON RESIDENT	3,718,616	17,478	38,957	450,231	4,225,282
5.02	00560	A&G PURCHASING & RECEIVING	280,435	0	32,508	39,147	0
5.03	00570	A&G ADMITTING	1,530,264	30,889	7,172	315,318	0
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE	0	0	0	0	0
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED	12,552,463	0	94,315	384,697	0
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00	00700	OPERATION OF PLANT	4,456,750	785,190	150,711	35	0
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0
9.00	00900	HOUSEKEEPING	1,431,826	20,389	67,341	191,621	0
10.00	01000	DIETARY	1,996,177	98,868	23,436	208,177	0
11.00	01100	CAFETERIA	397,917	0	0	94,392	0
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	636,171	0	0	125,687	0
14.00	01400	CENTRAL SERVICES & SUPPLY	705,480	0	109	82,203	0
15.00	01500	PHARMACY	0	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0
17.00	01700	SOCIAL SERVICE	990,231	0	0	206,827	0
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	25,647	0	119	5,357	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING PROGRAM	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,026,713	6,449	505	291,482	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	16,898,392	1,742,650	150,045	3,191,223	2,001,043
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	289,324	0	34,398	43,444	53,241
60.00	06000	LABORATORY	842,869	2,034	0	111,458	281,527
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	275,347	0	1,517	52,188	40,528
66.00	06600	PHYSICAL THERAPY	2,860,840	72,328	11,629	599,275	576,691
67.00	06700	OCCUPATIONAL THERAPY	2,050,191	0	5,480	423,403	508,142
68.00	06800	SPEECH PATHOLOGY	1,663,981	0	11,304	341,464	403,869
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	58,393	38,281	0	0	26,024
73.00	07300	DRUGS CHARGED TO PATIENTS	1,971,927	28,094	67,315	253,092	299,923
74.00	07400	RENAL DIALYSIS	282,743	0	0	0	34,057
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	WHEATON OUTPATIENT	2,316,075	0	31,604	460,814	67
90.02	09002	OTHER DAY HOSPITAL	6,325	0	20,274	16	170
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	70,886,253	2,842,650	748,739	7,871,551	4,225,282
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00	19100	RESEARCH	1,125	44,994	94,687	120	0
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	178,883	0	1,436	16,979	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	71,066,261	2,887,644	844,862	7,888,650	4,225,282

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet B
Part I
Date/Time Prepared:
1/25/2022 7:35 pm

Cost Center Description			A&G PURCHASING & RECEIVING	A&G ADMITTING	A&G PFS CASHIER/ACCTS RECEIVABLE	Subtotal	A&G OTHER INTERN & RESIDENT RELATED	
			5.02	5.03	5.04	5A.04	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	A&G NON INTERN & NON RESIDENT						5.01
5.02	00560	A&G PURCHASING & RECEIVING	352,090					5.02
5.03	00570	A&G ADMITTING	263	1,883,906				5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE	0	0	0			5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED	16,873	0	0	13,048,348	13,048,348	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	211	0	0	5,392,897	1,212,873	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	1,711,177	384,847	9.00
10.00	01000	DIETARY	784	0	0	2,327,442	523,446	10.00
11.00	01100	CAFETERIA	355	0	0	492,664	110,801	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	356	0	0	762,214	171,423	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,980	0	0	789,772	177,621	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	1,197,058	269,221	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	31,123	7,000	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	386	0	0	1,325,535	298,115	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	184,726	817,231	0	24,985,310	5,619,250	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	156	21,746	0	442,309	99,476	54.00
60.00	06000	LABORATORY	17	114,989	0	1,352,894	304,269	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	4,270	16,553	0	390,403	87,802	65.00
66.00	06600	PHYSICAL THERAPY	2,063	240,488	0	4,363,314	981,318	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,782	207,642	0	3,197,640	719,156	67.00
68.00	06800	SPEECH PATHOLOGY	1,969	165,767	0	2,588,354	582,126	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,282	10,629	0	139,609	31,398	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	124,839	122,503	0	2,867,693	644,950	73.00
74.00	07400	RENAL DIALYSIS	0	13,911	0	330,711	74,378	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	3,673	152,378	0	2,964,611	666,747	90.01
90.02	09002	OTHER DAY HOSPITAL	0	69	0	26,854	6,040	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	351,985	1,883,906	0	70,727,932	12,972,257	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	82	0	0	141,008	31,713	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	23	0	0	197,321	44,378	191.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	352,090	1,883,906	0	71,066,261	13,048,348	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet B
Part I
Date/Time Prepared:
1/25/2022 7:35 pm

Cost Center Description			MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	A&G NON INTERN & NON RESIDENT						5.01
5.02	00560	A&G PURCHASING & RECEIVING						5.02
5.03	00570	A&G ADMITTING						5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE						5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED						5.05
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	6,605,770				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0			8.00
9.00	00900	HOUSEKEEPING	0	65,568	0	2,161,592		9.00
10.00	01000	DIETARY	0	317,951	0	105,086	3,273,925	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	20,739	0	6,855	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	5,604,217	0	1,852,240	3,273,925	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	6,541	0	2,162	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	232,601	0	76,876	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	123,107	0	40,688	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	90,349	0	29,861	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	6,461,073	0	2,113,768	3,273,925	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	144,697	0	47,824	0	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	0	0	0	0	191.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	6,605,770	0	2,161,592	3,273,925	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet B
Part I
Date/Time Prepared:
1/25/2022 7:35 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
5.01	00590	A&G NON INTERN & NON RESIDENT						5.01
5.02	00560	A&G PURCHASING & RECEIVING						5.02
5.03	00570	A&G ADMITTING						5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE						5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	603,465					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	10,875	0	944,512			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,695	0	0	979,088		14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	18,460	0	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	920	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	28,508	0	0	1,140	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	347,444	0	944,512	545,970	0	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,554	0	0	461	0	54.00
60.00	06000	LABORATORY	10,792	0	0	49	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	5,140	0	0	12,622	0	65.00
66.00	06600	PHYSICAL THERAPY	60,504	0	0	6,098	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	37,881	0	0	8,223	0	67.00
68.00	06800	SPEECH PATHOLOGY	25,659	0	0	5,819	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	18,566	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	368,973	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	39,515	0	0	10,856	0	90.01
90.02	09002	OTHER DAY HOSPITAL	1	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	601,948	0	944,512	978,777	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	9	0	0	243	0	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	1,508	0	0	68	0	191.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	603,465	0	944,512	979,088	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet B
Part I
Date/Time Prepared:
1/25/2022 7:35 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	
			16.00	17.00	18.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	A&G NON INTERN & NON RESIDENT						5.01
5.02	00560	A&G PURCHASING & RECEIVING						5.02
5.03	00570	A&G ADMITTING						5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE						5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0					16.00
17.00	01700	SOCIAL SERVICE	0	1,484,739				17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	39,043			18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING PROGRAM	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	1,484,739	39,043	0	0	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,484,739	39,043	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	0	0	0	0	191.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,484,739	39,043	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet B
Part I
Date/Time Prepared:
1/25/2022 7:35 pm

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	A&G NON INTERN & NON RESIDENT						5.01
5.02	00560	A&G PURCHASING & RECEIVING						5.02
5.03	00570	A&G ADMITTING						5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE						5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)						18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING PROGRAM						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,680,892					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,680,892	0	0	46,377,542	-1,680,892	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	546,800	0	54.00
60.00	06000	LABORATORY	0	0	0	1,676,707	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	495,967	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,720,711	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,962,900	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,201,958	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	353,368	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,001,826	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	405,089	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	0	0	0	3,681,729	0	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	0	32,895	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,680,892	0	0	70,457,492	-1,680,892	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	365,494	0	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	0	0	243,275	0	191.01
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,680,892	0	0	71,066,261	-1,680,892	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet B
Part I
Date/Time Prepared:
1/25/2022 7:35 pm

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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet B
Part II
Date/Time Prepared:
1/25/2022 7:35 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
5.01	00590	A&G NON INTERN & NON RESIDENT	0	17,478	38,957	56,435	0 5.01
5.02	00560	A&G PURCHASING & RECEIVING	29,093	0	32,508	61,601	0 5.02
5.03	00570	A&G ADMITTING	5,314	30,889	7,172	43,375	0 5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE	0	0	0	0	0 5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED	1,205,724	0	94,315	1,300,039	0 5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0 6.00
7.00	00700	OPERATION OF PLANT	357,648	785,190	150,711	1,293,549	0 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0 8.00
9.00	00900	HOUSEKEEPING	6,938	20,389	67,341	94,668	0 9.00
10.00	01000	DIETARY	25,474	98,868	23,436	147,778	0 10.00
11.00	01100	CAFETERIA	0	0	0	0	0 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	147,475	0	109	147,584	0 14.00
15.00	01500	PHARMACY	0	0	0	0	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0 17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	119	119	0 18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0 20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	6,449	505	6,954	0 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0 22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,034	1,742,650	150,045	1,893,729	0 30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	34,398	34,398	0 54.00
60.00	06000	LABORATORY	0	2,034	0	2,034	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0	0	1,517	1,517	0 65.00
66.00	06600	PHYSICAL THERAPY	170	72,328	11,629	84,127	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	5,480	5,480	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	11,304	11,304	0 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	19,352	38,281	0	57,633	0 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	28,094	67,315	95,409	0 73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0 74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	WHEATON OUTPATIENT	3,083	0	31,604	34,687	0 90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	20,274	20,274	0 90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	0 92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,801,305	2,842,650	748,739	5,392,694	0 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
191.00	19100	RESEARCH	0	44,994	94,687	139,681	0 191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	0	1,436	1,436	0 191.01
200.00		Cross Foot Adjustments				0	0 200.00
201.00		Negative Cost Centers				0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	1,801,305	2,887,644	844,862	5,533,811	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet B
Part II
Date/Time Prepared:
1/25/2022 7:35 pm

Cost Center Description		A&G NON INTERN & NON RESIDENT	A&G PURCHASING & RECEIVING	A&G ADMITTING	A&G PFS CASHIER/ACCTS RECEIVABLE	A&G OTHER INTERN & RESIDENT RELATED	
		5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	A&G NON INTERN & NON RESIDENT	56,435				5.01
5.02	00560	A&G PURCHASING & RECEIVING	0	61,601			5.02
5.03	00570	A&G ADMITTING	0	46	43,421		5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE	0	0	0		5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED	0	2,952	0	1,302,991	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	37	0	121,114	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	38,430	9.00
10.00	01000	DIETARY	0	137	0	52,270	10.00
11.00	01100	CAFETERIA	0	62	0	11,064	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	62	0	17,118	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	346	0	17,737	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	26,884	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	699	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	67	0	29,769	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	26,702	32,321	18,795	0	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	712	27	502	0	54.00
60.00	06000	LABORATORY	3,763	3	2,655	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	542	747	382	0	65.00
66.00	06600	PHYSICAL THERAPY	7,709	361	5,552	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,793	487	4,794	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,399	344	3,827	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	348	1,099	245	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,009	21,842	2,828	0	73.00
74.00	07400	RENAL DIALYSIS	455	0	321	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	WHEATON OUTPATIENT	1	643	3,518	0	90.01
90.02	09002	OTHER DAY HOSPITAL	2	0	2	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	56,435	61,583	43,421	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	14	0	0	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	4	0	0	191.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	56,435	61,601	43,421	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet B
Part II
Date/Time Prepared:
1/25/2022 7:35 pm

Cost Center Description			MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	A&G NON INTERN & NON RESIDENT						5.01
5.02	00560	A&G PURCHASING & RECEIVING						5.02
5.03	00570	A&G ADMITTING						5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE						5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED						5.05
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	1,414,700				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0			8.00
9.00	00900	HOUSEKEEPING	0	14,042	0	147,140		9.00
10.00	01000	DIETARY	0	68,093	0	7,153	275,431	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	4,442	0	467	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	1,200,205	0	126,082	275,431	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	1,401	0	147	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	49,814	0	5,233	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	26,365	0	2,770	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,349	0	2,033	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,383,711	0	143,885	275,431	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	30,989	0	3,255	0	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	0	0	0	0	191.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,414,700	0	147,140	275,431	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet B
Part II
Date/Time Prepared:
1/25/2022 7:35 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
5.01	00590	A&G NON INTERN & NON RESIDENT						5.01
5.02	00560	A&G PURCHASING & RECEIVING						5.02
5.03	00570	A&G ADMITTING						5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE						5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	11,126					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	200	0	17,380			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	216	0	0	165,883		14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	340	0	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	17	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	526	0	0	193	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,407	0	17,380	92,503	0	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	84	0	0	78	0	54.00
60.00	06000	LABORATORY	199	0	0	8	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	95	0	0	2,138	0	65.00
66.00	06600	PHYSICAL THERAPY	1,115	0	0	1,033	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	698	0	0	1,393	0	67.00
68.00	06800	SPEECH PATHOLOGY	473	0	0	986	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,146	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	62,513	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	728	0	0	1,839	0	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,098	0	17,380	165,830	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	41	0	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	28	0	0	12	0	191.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	11,126	0	17,380	165,883	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet B
Part II
Date/Time Prepared:
1/25/2022 7:35 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	
			16.00	17.00	18.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	A&G NON INTERN & NON RESIDENT						5.01
5.02	00560	A&G PURCHASING & RECEIVING						5.02
5.03	00570	A&G ADMITTING						5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE						5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0					16.00
17.00	01700	SOCIAL SERVICE	0	27,224				17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	835			18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING PROGRAM	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	27,224	835			30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0			44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0			54.00
60.00	06000	LABORATORY	0	0	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0			65.00
66.00	06600	PHYSICAL THERAPY	0	0	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0			68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0			71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0			73.00
74.00	07400	RENAL DIALYSIS	0	0	0			74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	0	0	0			90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	0			90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	27,224	835	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190.00
191.00	19100	RESEARCH	0	0	0			191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	0	0			191.01
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	27,224	835	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet B
Part II
Date/Time Prepared:
1/25/2022 7:35 pm

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	A&G NON INTERN & NON RESIDENT						5.01
5.02	00560	A&G PURCHASING & RECEIVING						5.02
5.03	00570	A&G ADMITTING						5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE						5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)						18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING PROGRAM						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	42,418					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM (SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				4,278,758	0	30.00
44.00	04400	SKILLED NURSING FACILITY				0	0	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC				45,734	0	54.00
60.00	06000	LABORATORY				40,593	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
65.00	06500	RESPIRATORY THERAPY				14,189	0	65.00
66.00	06600	PHYSICAL THERAPY				252,935	0	66.00
67.00	06700	OCCUPATIONAL THERAPY				91,458	0	67.00
68.00	06800	SPEECH PATHOLOGY				80,462	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				94,741	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS				272,386	0	73.00
74.00	07400	RENAL DIALYSIS				8,203	0	74.00
76.97	07697	CARDIAC REHABILITATION				0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				0	0	76.98
76.99	07699	LITHOTRIPSY				0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT				107,995	0	90.01
90.02	09002	OTHER DAY HOSPITAL				20,881	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	5,308,335	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				0	0	190.00
191.00	19100	RESEARCH				177,147	0	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE				5,911	0	191.01
200.00		Cross Foot Adjustments	42,418	0	0	42,418	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	42,418	0	0	5,533,811	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet B
Part II
Date/Time Prepared:
1/25/2022 7:35 pm

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-3027

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

Worksheet B-1

Date/Time Prepared:
1/25/2022 7:35 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	A&G NON INTERN & NON RESIDENT (INPATIENT REVENUE)	A&G PURCHASING & RECEIVING (ALLOCATION 1)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	174,629					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		844,861				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	37,768,732			4.00
5.01	00590	A&G NON INTERN & NON RESIDENT	1,057	38,957	2,155,589	152,656,304		5.01
5.02	00560	A&G PURCHASING & RECEIVING	0	32,508	187,424	0	2,041,396	5.02
5.03	00570	A&G ADMITTING	1,868	7,172	1,509,657	0	1,524	5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE	0	0	0	0	0	5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED	0	94,315	1,841,827	0	97,829	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	47,484	150,710	167	0	1,221	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,233	67,341	917,433	0	2	9.00
10.00	01000	DIETARY	5,979	23,436	996,695	0	4,544	10.00
11.00	01100	CAFETERIA	0	0	451,923	0	2,061	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	601,757	0	2,066	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	109	393,565	0	11,479	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	990,231	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	119	25,647	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	390	505	1,395,537	0	2,236	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	105,386	150,045	15,278,701	72,295,090	1,071,023	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	34,398	207,998	1,923,568	905	54.00
60.00	06000	LABORATORY	123	0	533,632	10,171,518	97	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,517	249,860	1,464,260	24,760	65.00
66.00	06600	PHYSICAL THERAPY	4,374	11,629	2,869,172	20,835,701	11,962	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,480	2,027,144	18,359,058	16,131	67.00
68.00	06800	SPEECH PATHOLOGY	0	11,304	1,634,839	14,591,696	11,415	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,315	0	0	940,232	36,421	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,699	67,315	1,211,736	10,836,147	723,812	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,230,478	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	0	31,604	2,206,257	2,431	21,297	90.01
90.02	09002	OTHER DAY HOSPITAL	0	20,274	75	6,125	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	171,908	748,738	37,686,866	152,656,304	2,040,785	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	2,721	94,687	574	0	477	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	1,436	81,292	0	134	191.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,887,644	844,862	7,888,650	4,225,282	352,090	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.535879	1.000001	0.208867	0.027678	0.172475	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	56,435	61,601	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	0.000370	0.030176	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-3027

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

Worksheet B-1

Date/Time Prepared:
1/25/2022 7:35 pm

Cost Center Description			A&G ADMITTING (GROSS REVENUE)	A&G PFS CASHIER/ACCTS RECEIVABLE (INPATIENT REVENUE)	Reconciliation	A&G OTHER INTERN & RESIDENT RELATED (ACCUM COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
			5.03	5.04	5A.05	5.05	6.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	A&G NON INTERN & NON RESIDENT						5.01
5.02	00560	A&G PURCHASING & RECEIVING						5.02
5.03	00570	A&G ADMITTING	166,649,302					5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE	0	152,656,304				5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED	0	0	-13,048,348	58,017,913		5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	171,704	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	5,392,897	47,484	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	1,711,177	1,233	9.00
10.00	01000	DIETARY	0	0	0	2,327,442	5,979	10.00
11.00	01100	CAFETERIA	0	0	0	492,664	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	762,214	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	789,772	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	1,197,058	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	31,123	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	1,325,535	390	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	72,295,090	72,295,090	0	24,985,310	105,386	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,923,568	1,923,568	0	442,309	0	54.00
60.00	06000	LABORATORY	10,171,518	10,171,518	0	1,352,894	123	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,464,260	1,464,260	0	390,403	0	65.00
66.00	06600	PHYSICAL THERAPY	21,272,677	20,835,701	0	4,363,314	4,374	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,367,259	18,359,058	0	3,197,640	0	67.00
68.00	06800	SPEECH PATHOLOGY	14,663,126	14,591,696	0	2,588,354	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	940,232	940,232	0	139,609	2,315	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,836,147	10,836,147	0	2,867,693	1,699	73.00
74.00	07400	RENAL DIALYSIS	1,230,478	1,230,478	0	330,711	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	13,478,822	2,431	0	2,964,611	0	90.01
90.02	09002	OTHER DAY HOSPITAL	6,125	6,125	0	26,854	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	166,649,302	152,656,304	-13,048,348	57,679,584	168,983	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	141,008	2,721	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	0	0	197,321	0	191.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,883,906	0		13,048,348	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.011305	0.000000		0.224902	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	43,421	0		1,302,991	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000261	0.000000		0.022458	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-3027

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

Worksheet B-1

Date/Time Prepared:
1/25/2022 7:35 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	A&G NON INTERN & NON RESIDENT					5.01
5.02	00560	A&G PURCHASING & RECEIVING					5.02
5.03	00570	A&G ADMITTING					5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE					5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED					5.05
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT	124,220				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0			8.00
9.00	00900	HOUSEKEEPING	1,233	0	122,987		9.00
10.00	01000	DIETARY	5,979	0	5,979	42,917	10.00
11.00	01100	CAFETERIA	0	0	0	825,466	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	14,876	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	15,998	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	25,251	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	1,258	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	390	0	390	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	105,386	0	105,386	42,917	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	6,229	54.00
60.00	06000	LABORATORY	123	0	123	14,762	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,031	65.00
66.00	06600	PHYSICAL THERAPY	4,374	0	4,374	82,762	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	51,817	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	35,098	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,315	0	2,315	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,699	0	1,699	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	WHEATON OUTPATIENT	0	0	0	54,051	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	0	2	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	121,499	0	120,266	42,917	823,391
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100	RESEARCH	2,721	0	2,721	12	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	0	0	2,063	191.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,605,770	0	2,161,592	3,273,925	603,465
203.00		Unit cost multiplier (Wkst. B, Part I)	53.177991	0.000000	17.575776	76.285039	0.731060
204.00		Cost to be allocated (per Wkst. B, Part II)	1,414,700	0	147,140	275,431	11,126
205.00		Unit cost multiplier (Wkst. B, Part II)	11.388665	0.000000	1.196387	6.417760	0.013478
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: 14-3027

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

Worksheet B-1

Date/Time Prepared:
1/25/2022 7:35 pm

Cost Center Description			MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (ALLOCATION 2)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
			12.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	A&G NON INTERN & NON RESIDENT						5.01
5.02	00560	A&G PURCHASING & RECEIVING						5.02
5.03	00570	A&G ADMITTING						5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE						5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0					12.00
13.00	01300	NURSING ADMINISTRATION	0	1,000				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,920,670			14.00
15.00	01500	PHARMACY	0	0	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	166,649,302	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	2,236	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	1,000	1,071,023	0	72,295,090	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	905	0	1,923,568	54.00
60.00	06000	LABORATORY	0	0	97	0	10,171,518	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	24,760	0	1,464,260	65.00
66.00	06600	PHYSICAL THERAPY	0	0	11,962	0	21,272,677	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	16,131	0	18,367,259	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	11,415	0	14,663,126	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	36,421	0	940,232	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	723,812	0	10,836,147	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	1,230,478	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	0	0	21,297	0	13,478,822	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	0	0	6,125	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,000	1,920,059	0	166,649,302	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	477	0	0	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	0	134	0	0	191.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	944,512	979,088	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	944.512000	0.509764	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	17,380	165,883	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	17.380000	0.086367	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-3027

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

Worksheet B-1

Date/Time Prepared:
1/25/2022 7:35 pm

Cost Center Description			SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE (SPECIFY) (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING PROGRAM (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			17.00	18.00	19.00	20.00	21.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	A&G NON INTERN & NON RESIDENT						5.01
5.02	00560	A&G PURCHASING & RECEIVING						5.02
5.03	00570	A&G ADMITTING						5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE						5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	1,000					17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	1,000				18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING PROGRAM	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			1,000	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,000	1,000	0	0	1,000	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,000	1,000	0	0	1,000	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	0	0	0	0	0	191.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,484,739	39,043	0	0	1,680,892	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1,484.739000	39.043000	0.000000	0.000000	1,680.892000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	27,224	835	0	0	42,418	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	27.224000	0.835000	0.000000	0.000000	42.418000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet B-1
Date/Time Prepared:
1/25/2022 7:35 pm

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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet C
Part I
Date/Time Prepared:
1/25/2022 7:35 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	44,696,650		44,696,650	0	44,696,650	30.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	546,800		546,800	0	546,800	54.00
60.00	06000	LABORATORY	1,676,707		1,676,707	0	1,676,707	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	495,967	0	495,967	0	495,967	65.00
66.00	06600	PHYSICAL THERAPY	5,720,711	0	5,720,711	0	5,720,711	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,962,900	0	3,962,900	0	3,962,900	67.00
68.00	06800	SPEECH PATHOLOGY	3,201,958	0	3,201,958	0	3,201,958	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	353,368		353,368	0	353,368	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,001,826		4,001,826	0	4,001,826	73.00
74.00	07400	RENAL DIALYSIS	405,089		405,089	0	405,089	74.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	3,681,729		3,681,729	0	3,681,729	90.01
90.02	09002	OTHER DAY HOSPITAL	32,895		32,895	0	32,895	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0	0	0	92.00
200.00		Subtotal (see instructions)	68,776,600	0	68,776,600	0	68,776,600	200.00
201.00		Less Observation Beds	0		0	0	0	201.00
202.00		Total (see instructions)	68,776,600	0	68,776,600	0	68,776,600	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet C
Part I
Date/Time Prepared:
1/25/2022 7:35 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	72,295,090		72,295,090			30.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
	ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,923,568	0	1,923,568	0.284263	0.000000	54.00
60.00	06000	LABORATORY	10,171,518	0	10,171,518	0.164843	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	1,464,260	0	1,464,260	0.338715	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	20,835,701	436,976	21,272,677	0.268923	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,359,058	8,201	18,367,259	0.215759	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	14,591,696	71,430	14,663,126	0.218368	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	940,232	0	940,232	0.375831	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,836,147	0	10,836,147	0.369303	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,230,478	0	1,230,478	0.329213	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	09001	WHEATON OUTPATIENT	2,431	13,476,391	13,478,822	0.273149	0.000000	90.01
90.02	09002	OTHER DAY HOSPITAL	6,125	0	6,125	5.370612	0.000000	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
200.00		Subtotal (see instructions)	152,656,304	13,992,998	166,649,302			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	152,656,304	13,992,998	166,649,302			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet C
Part I
Date/Time Prepared:
1/25/2022 7:35 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
44.00	04400 SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.284263			54.00
60.00	06000 LABORATORY	0.164843			60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500 RESPIRATORY THERAPY	0.338715			65.00
66.00	06600 PHYSICAL THERAPY	0.268923			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.215759			67.00
68.00	06800 SPEECH PATHOLOGY	0.218368			68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.375831			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.369303			73.00
74.00	07400 RENAL DIALYSIS	0.329213			74.00
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699 LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	09001 WHEATON OUTPATIENT	0.273149			90.01
90.02	09002 OTHER DAY HOSPITAL	5.370612			90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet C
Part I
Date/Time Prepared:
1/25/2022 7:35 pm

			Title XIX		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	46,377,542		46,377,542	0	46,377,542	30.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	546,800		546,800	0	546,800	54.00
60.00	06000	LABORATORY	1,676,707		1,676,707	0	1,676,707	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	495,967	0	495,967	0	495,967	65.00
66.00	06600	PHYSICAL THERAPY	5,720,711	0	5,720,711	0	5,720,711	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,962,900	0	3,962,900	0	3,962,900	67.00
68.00	06800	SPEECH PATHOLOGY	3,201,958	0	3,201,958	0	3,201,958	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	353,368		353,368	0	353,368	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,001,826		4,001,826	0	4,001,826	73.00
74.00	07400	RENAL DIALYSIS	405,089		405,089	0	405,089	74.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	3,681,729		3,681,729	0	3,681,729	90.01
90.02	09002	OTHER DAY HOSPITAL	32,895		32,895	0	32,895	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Subtotal (see instructions)	70,457,492	0	70,457,492	0	70,457,492	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	70,457,492	0	70,457,492	0	70,457,492	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet C
Part I
Date/Time Prepared:
1/25/2022 7:35 pm

				Title XIX		Hospital		PPS		
	Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
				Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00	9.00	10.00					
	INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0		0				30.00	
44.00	04400	SKILLED NURSING FACILITY	0		0				44.00	
	ANCILLARY SERVICE COST CENTERS									
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000		54.00	
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000		60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000		62.30	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	0.000000		65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000		66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000		67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000		68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000		71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000		73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000		74.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000		76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000		76.98	
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000		76.99	
	OUTPATIENT SERVICE COST CENTERS									
90.01	09001	WHEATON OUTPATIENT	0	0	0	0.000000	0.000000		90.01	
90.02	09002	OTHER DAY HOSPITAL	0	0	0	0.000000	0.000000		90.02	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000		92.00	
200.00		Subtotal (see instructions)	0	0	0				200.00	
201.00		Less Observation Beds							201.00	
202.00		Total (see instructions)	0	0	0				202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet C
Part I
Date/Time Prepared:
1/25/2022 7:35 pm

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

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

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet C
Part II
Date/Time Prepared:
1/25/2022 7:35 pm

Cost Center Description			Title XIX		Hospital	PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	546,800	45,734	501,066	0	0
60.00	06000	LABORATORY	1,676,707	40,593	1,636,114	0	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	495,967	14,189	481,778	0	0
66.00	06600	PHYSICAL THERAPY	5,720,711	252,935	5,467,776	0	0
67.00	06700	OCCUPATIONAL THERAPY	3,962,900	91,458	3,871,442	0	0
68.00	06800	SPEECH PATHOLOGY	3,201,958	80,462	3,121,496	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	353,368	94,741	258,627	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	4,001,826	272,386	3,729,440	0	0
74.00	07400	RENAL DIALYSIS	405,089	8,203	396,886	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	WHEATON OUTPATIENT	3,681,729	107,995	3,573,734	0	0
90.02	09002	OTHER DAY HOSPITAL	32,895	20,881	12,014	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
200.00		Subtotal (sum of lines 50 thru 199)	24,079,950	1,029,577	23,050,373	0	0
201.00		Less Observation Beds	0	0	0	0	0
202.00		Total (line 200 minus line 201)	24,079,950	1,029,577	23,050,373	0	0

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

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet C
Part II
Date/Time Prepared:
1/25/2022 7:35 pm

			Title XIX		Hospital	PPS
Cost Center Description			Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	546,800	1,923,568	0.284263	54.00
60.00	06000	LABORATORY	1,676,707	10,171,518	0.164843	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	495,967	1,464,260	0.338715	65.00
66.00	06600	PHYSICAL THERAPY	5,720,711	21,272,677	0.268923	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,962,900	18,367,259	0.215759	67.00
68.00	06800	SPEECH PATHOLOGY	3,201,958	14,663,126	0.218368	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	353,368	940,232	0.375831	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,001,826	10,836,147	0.369303	73.00
74.00	07400	RENAL DIALYSIS	405,089	1,230,478	0.329213	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	76.99
	OUTPATIENT SERVICE COST CENTERS					
90.01	09001	WHEATON OUTPATIENT	3,681,729	13,478,822	0.273149	90.01
90.02	09002	OTHER DAY HOSPITAL	32,895	6,125	5.370612	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	92.00
200.00		Subtotal (sum of lines 50 thru 199)	24,079,950	94,354,212		200.00
201.00		Less Observation Beds	0	0		201.00
202.00		Total (line 200 minus line 201)	24,079,950	94,354,212		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet D
Part I
Date/Time Prepared:
1/25/2022 7:35 pm

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Hospital Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		4,278,758	0	4,278,758	42,917	99.70	30.00
44.00	SKILLED NURSING FACILITY		0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)		4,278,758		4,278,758	42,917		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		20,236	2,017,529				
44.00	SKILLED NURSING FACILITY		0	0				
200.00	Total (lines 30 through 199)		20,236	2,017,529				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet D
Part II
Date/Time Prepared:
1/25/2022 7:35 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								
54.00	05400	RADIOLOGY-DIAGNOSTIC	45,734	1,923,568	0.023776	1,008,897	23,988	54.00
60.00	06000	LABORATORY	40,593	10,171,518	0.003991	4,927,951	19,667	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	14,189	1,464,260	0.009690	780,822	7,566	65.00
66.00	06600	PHYSICAL THERAPY	252,935	21,272,677	0.011890	10,030,895	119,267	66.00
67.00	06700	OCCUPATIONAL THERAPY	91,458	18,367,259	0.004979	8,769,831	43,665	67.00
68.00	06800	SPEECH PATHOLOGY	80,462	14,663,126	0.005487	6,993,555	38,374	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	94,741	940,232	0.100763	541,913	54,605	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	272,386	10,836,147	0.025137	5,116,232	128,607	73.00
74.00	07400	RENAL DIALYSIS	8,203	1,230,478	0.006667	644,007	4,294	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	107,995	13,478,822	0.008012	710	6	90.01
90.02	09002	OTHER DAY HOSPITAL	20,881	6,125	3.409143	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	1,029,577	94,354,212		38,814,813	440,039	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-3027		Period: From 09/01/2020 To 08/31/2021		Worksheet D Part III Date/Time Prepared: 1/25/2022 7:35 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	0	30.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	0	44.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	42,917	0.00	20,236	0	0	30.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0.00	0	0	0	44.00	
200.00		Total (lines 30 through 199)	0	0	42,917	0	20,236	0	0	200.00	
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0						30.00	
44.00	04400	SKILLED NURSING FACILITY	0	0						44.00	
200.00		Total (lines 30 through 199)	0	0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-3027

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

Worksheet D
Part IV
Date/Time Prepared:
1/25/2022 7:35 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								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-3027

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

Worksheet D
Part IV
Date/Time Prepared:
1/25/2022 7:35 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								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,923,568	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	10,171,518	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,464,260	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	21,272,677	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	18,367,259	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	14,663,126	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	940,232	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,836,147	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,230,478	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	0	0	0	13,478,822	0.000000	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	0	6,125	0.000000	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	94,354,212		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet D
Part IV
Date/Time Prepared:
1/25/2022 7:35 pm

Cost Center Description			Title XVIII		Hospital		PPS
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
			9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,008,897	0	0	0
60.00	06000	LABORATORY	0.000000	4,927,951	0	0	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0.000000	780,822	0	0	0
66.00	06600	PHYSICAL THERAPY	0.000000	10,030,895	0	261	0
67.00	06700	OCCUPATIONAL THERAPY	0.000000	8,769,831	0	0	0
68.00	06800	SPEECH PATHOLOGY	0.000000	6,993,555	0	61,296	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	541,913	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	5,116,232	0	0	0
74.00	07400	RENAL DIALYSIS	0.000000	644,007	0	0	0
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	WHEATON OUTPATIENT	0.000000	710	0	26,328	0
90.02	09002	OTHER DAY HOSPITAL	0.000000	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0
200.00		Total (lines 50 through 199)		38,814,813	0	87,885	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet D
Part V
Date/Time Prepared:
1/25/2022 7:35 pm

			Title XVIII		Hospital		PPS		
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.284263	0	0	0	0	54.00	
60.00	06000	LABORATORY	0.164843	0	0	0	0	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	0.338715	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.268923	261	0	0	70	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.215759	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.218368	61,296	0	0	13,385	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.375831	0	0	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.369303	0	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0.329213	0	0	0	0	74.00	
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99	
	OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	0.273149	26,328	0	0	7,191	90.01	
90.02	09002	OTHER DAY HOSPITAL	5.370612	0	0	0	0	90.02	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00	
200.00		Subtotal (see instructions)		87,885	0	0	20,646	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		87,885	0	0	20,646	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-3027		Period: From 09/01/2020 To 08/31/2021		Worksheet D Part V Date/Time Prepared: 1/25/2022 7:35 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
60.00	06000	LABORATORY	0	0					60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0					62.30
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0					67.00
68.00	06800	SPEECH PATHOLOGY	0	0					68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0					71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0					73.00
74.00	07400	RENAL DIALYSIS	0	0					74.00
76.97	07697	CARDIAC REHABILITATION	0	0					76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0					76.98
76.99	07699	LITHOTRIPSY	0	0					76.99
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	WHEATON OUTPATIENT	0	0					90.01
90.02	09002	OTHER DAY HOSPITAL	0	0					90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					92.00
200.00		Subtotal (see instructions)	0	0					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	0					202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet D
Part I
Date/Time Prepared:
1/25/2022 7:35 pm

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Hospital Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		4,278,758	0	4,278,758	42,917	99.70	30.00
44.00	SKILLED NURSING FACILITY		0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)		4,278,758		4,278,758	42,917		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		3,068	305,880				
44.00	SKILLED NURSING FACILITY		0	0				
200.00	Total (lines 30 through 199)		3,068	305,880				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet D
Part II
Date/Time Prepared:
1/25/2022 7:35 pm

Cost Center Description			Title XIX		Hospital	PPS	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	45,734	0	0.000000	0	0 54.00
60.00	06000	LABORATORY	40,593	0	0.000000	0	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	14,189	0	0.000000	0	0 65.00
66.00	06600	PHYSICAL THERAPY	252,935	0	0.000000	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	91,458	0	0.000000	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	80,462	0	0.000000	0	0 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	94,741	0	0.000000	0	0 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	272,386	0	0.000000	0	0 73.00
74.00	07400	RENAL DIALYSIS	8,203	0	0.000000	0	0 74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	WHEATON OUTPATIENT	107,995	0	0.000000	0	0 90.01
90.02	09002	OTHER DAY HOSPITAL	20,881	0	0.000000	0	0 90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0 92.00
200.00		Total (lines 50 through 199)	1,029,577	0		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet D
Part III
Date/Time Prepared:
1/25/2022 7:35 pm

				Title XIX		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	30.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00	
200.00		Total (lines 30 through 199)	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	42,917	0.00	3,068	30.00	
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00	
200.00		Total (lines 30 through 199)		0	42,917		3,068	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0						30.00
44.00	04400	SKILLED NURSING FACILITY	0						44.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-3027		Period: From 09/01/2020 To 08/31/2021		Worksheet D Part IV Date/Time Prepared: 1/25/2022 7:35 pm	
			Title XIX		Hospital		PPS	
Cost Center Description			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								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-3027

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

Worksheet D
Part IV
Date/Time Prepared:
1/25/2022 7:35 pm

Cost Center Description			Title XIX		Hospital		PPS	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	0	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	0	0	0	0	0.000000	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	0	0	0.000000	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet D
Part IV
Date/Time Prepared:
1/25/2022 7:35 pm

				Title XIX		Hospital		PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			9.00						10.00
	ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00	
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00	
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99	
	OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	0.000000	0	0	0	0	90.01	
90.02	09002	OTHER DAY HOSPITAL	0.000000	0	0	0	0	90.02	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00	
200.00		Total (lines 50 through 199)		0	0	0	0	200.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-3027	Period: From 09/01/2020 To 08/31/2021	Worksheet D-1 Date/Time Prepared: 1/25/2022 7:35 pm
Cost Center Description		Title XVIII	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		42,917	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		42,917	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)		42,917	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)		20,236	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)		44,696,650	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)		44,696,650	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)		44,696,650	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,041.47	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		21,075,187	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)		21,075,187	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-3027

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

Worksheet D-1

Date/Time Prepared:
1/25/2022 7:35 pm

Cost Center Description		Title XVIII			Hospital	PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					9,785,800	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					30,860,987	49.00
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					2,017,529	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					440,039	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,457,568	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					28,403,419	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-3027

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

Worksheet D-1

Date/Time Prepared:
1/25/2022 7:35 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	4,278,758	44,696,650	0.095729	0	0	90.00
91.00	Nursing Program cost	0	44,696,650	0.000000	0	0	91.00
92.00	Allied health cost	0	44,696,650	0.000000	0	0	92.00
93.00	All other Medical Education	0	44,696,650	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-3027	Period: From 09/01/2020 To 08/31/2021	Worksheet D-1 Date/Time Prepared: 1/25/2022 7:35 pm
Cost Center Description		Title XIX	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		42,917	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		42,917	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)		42,917	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)		3,068	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)		46,377,542	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)		46,377,542	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)		46,377,542	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)		1,080.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,315,373	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)		3,315,373	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-3027

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

Worksheet D-1

Date/Time Prepared:
1/25/2022 7:35 pm

Cost Center Description		Title XIX		Hospital	PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)					42.00
	Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
	Cost Center Description					
					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,315,373 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)					305,880 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)					305,880 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,009,493 53.00
	TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges					0 54.00
55.00	Target amount per discharge					0.00 55.00
56.00	Target amount (line 54 x line 55)					0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00	Bonus payment (see instructions)					0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00	Relief payment (see instructions)					0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)					0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-3027

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

Worksheet D-1

Date/Time Prepared:
1/25/2022 7:35 pm

Cost Center Description		Title XIX		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	4,278,758	46,377,542	0.092259	0	0 90.00
91.00	Nursing Program cost	0	46,377,542	0.000000	0	0 91.00
92.00	Allied health cost	0	46,377,542	0.000000	0	0 92.00
93.00	All other Medical Education	0	46,377,542	0.000000	0	0 93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-3027	Period: From 09/01/2020 To 08/31/2021	Worksheet D-3 Date/Time Prepared: 1/25/2022 7:35 pm	
Cost Center Description		Title XVIII	Hospital	PPS	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		30,427,950		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.284263	1,008,897	286,792	54.00
60.00	06000 LABORATORY	0.164843	4,927,951	812,338	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.338715	780,822	264,476	65.00
66.00	06600 PHYSICAL THERAPY	0.268923	10,030,895	2,697,538	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.215759	8,769,831	1,892,170	67.00
68.00	06800 SPEECH PATHOLOGY	0.218368	6,993,555	1,527,169	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.375831	541,913	203,668	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.369303	5,116,232	1,889,440	73.00
74.00	07400 RENAL DIALYSIS	0.329213	644,007	212,015	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	09001 WHEATON OUTPATIENT	0.273149	710	194	90.01
90.02	09002 OTHER DAY HOSPITAL	5.370612	0	0	90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		38,814,813	9,785,800	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		38,814,813		202.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
1/25/2022 7:35 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	0
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0	0	0	0	0
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0	0	0
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0	0	0	0
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	722,498	-722,498	0
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	0
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	0
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000	0
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0
11.01	Uncompensated care payments	36.00	0	0	0	0	0
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	0	0	0	0	0
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	0	0	0	0	0
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	0	0	0	0	0

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
1/25/2022 7:35 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	0	0	0	0	0
17.01	Net organ aquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	0	0	0
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	0	0	0	0	0
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	0	0	0	0	0
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0
26.00	Total prospective capital payments (see instructions)	12.00	0	0	0	0	0
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.000000	0.000000	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
1/25/2022 7:35 pm

		Title XVIII		Hospital		PPS
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)
		0	1.00	2.00	3.00	4.00
1.00	DRG amounts other than outlier payments	1.00				1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0		0
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0		0	0
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0
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
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0		0
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0
3.00	Operating outlier reconciliation	2.01	0	0	0	0
4.00	Managed care simulated payments	3.00	0	722,498	10,244,969	10,967,467
Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0
Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0
11.01	Uncompensated care payments	36.00	0	0	0	0
Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0
13.00	Subtotal (see instructions)	47.00	0	0	0	0
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	0	0	0	0
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	0	0	0	0
17.00	Special add-on payments for new technologies	54.00	0	0	0	0
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
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0
19.00	SUBTOTAL			0	0	0

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
1/25/2022 7:35 pm

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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-3027	Period: From 09/01/2020 To 08/31/2021	Worksheet E Part B Date/Time Prepared: 1/25/2022 7:35 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		20,646	2.00
3.00	OPPS payments		13,878	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.943	5.00
6.00	Line 2 times line 5		19,469	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		71.28	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		13,878	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,842	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)		11,036	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		510	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)		11,546	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		11,546	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)		183	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		119	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		167	36.00
37.00	Subtotal (see instructions)		11,665	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		11,665	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		11,036	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		629	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet E-1
Part I
Date/Time Prepared:
1/25/2022 7:35 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		38,948,911		11,036	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		755,115		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	05/20/2021	169,738		0	3.50	
3.51		08/30/2021	32,576		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)		-202,314		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		39,501,712		11,036	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		629	6.01	
6.02	SETTLEMENT TO PROGRAM		218,553		0	6.02	
7.00	Total Medicare program liability (see instructions)		39,283,159		11,665	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: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet E-1
Part II
Date/Time Prepared:
1/25/2022 7:35 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: 14-3027	Period: From 09/01/2020 To 08/31/2021	Worksheet E-3 Part III Date/Time Prepared: 1/25/2022 7:35 pm
		Title XVIII	Hospital	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)		33,881,617	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0.0101	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		1,517,896	3.00
4.00	Outlier Payments		601,847	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)		12.75	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	5.01
6.00	New Teaching program adjustment. (see instructions)		0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		9.97	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)		9.97	9.00
10.00	Average Daily Census (see instructions)		117.580822	10.00
11.00	Teaching Adjustment Factor (see instructions)		0.086233	11.00
12.00	Teaching Adjustment (see instructions)		2,921,713	12.00
13.00	Total PPS Payment (see instructions)		38,923,073	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)		0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		0	15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)		0	16.00
17.00	Subtotal (see instructions)		38,923,073	17.00
18.00	Primary payer payments		0	18.00
19.00	Subtotal (line 17 less line 18).		38,923,073	19.00
20.00	Deductibles		166,136	20.00
21.00	Subtotal (line 19 minus line 20)		38,756,937	21.00
22.00	Coinsurance		275,695	22.00
23.00	Subtotal (line 21 minus line 22)		38,481,242	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		61,694	24.00
25.00	Adjusted reimbursable bad debts (see instructions)		40,101	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		47,295	26.00
27.00	Subtotal (sum of lines 23 and 25)		38,521,343	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		761,816	28.00
29.00	Other pass through costs (see instructions)		0	29.00
30.00	Outlier payments reconciliation		0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS)		0	31.00
31.01	MSP PASS THROUGH		0	31.01
31.02	MSP LLC ADJUSTMENT		0	31.02
31.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	31.50
31.98	Recovery of accelerated depreciation.		0	31.98
31.99	Demonstration payment adjustment amount before sequestration		0	31.99
32.00	Total amount payable to the provider (see instructions)		39,283,159	32.00
32.01	Sequestration adjustment (see instructions)		0	32.01
32.02	Demonstration payment adjustment amount after sequestration		0	32.02
33.00	Interim payments		39,501,712	33.00
34.00	Tentative settlement (for contractor use only)		0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)		-218,553	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		2,161,078	36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4		601,847	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-3027		Period: From 09/01/2020 To 08/31/2021		Worksheet E-4 Date/Time Prepared: 1/25/2022 7:35 pm	
		Title XVIII		Hospital		PPS	
						1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT							
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.					13.88	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)					0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA					1.28	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)					0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))					0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)					0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)					0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)					12.60	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)					9.97	6.00
7.00	Enter the lesser of line 5 or line 6					9.97	7.00
		Primary Care		Other		Total	
		1.00		2.00		3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00		9.97		9.97 8.00	
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00		9.97		9.97 9.00	
10.00	Weighted dental and podiatric resident FTE count for the current year			0.00		10.00	
10.01	Unweighted dental and podiatric resident FTE count for the current year			0.00		10.01	
11.00	Total weighted FTE count	0.00		9.97		11.00	
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00		10.61		12.00	
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00		10.81		13.00	
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00		10.46		14.00	
15.00	Adjustment for residents in initial years of new programs	0.00		0.00		15.00	
15.01	Unweighted adjustment for residents in initial years of new programs	0.00		0.00		15.01	
16.00	Adjustment for residents displaced by program or hospital closure	0.00		0.00		16.00	
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00		0.00		16.01	
17.00	Adjusted rolling average FTE count	0.00		10.46		17.00	
18.00	Per resident amount	120,926.48		117,197.33		18.00	
19.00	Approved amount for resident costs	0		1,225,884		1,225,884 19.00	
						1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)					0.00 20.00	
21.00	Direct GME FTE unweighted resident count over cap (see instructions)					0.00 21.00	
22.00	Allowable additional direct GME FTE Resident Count (see instructions)					0.00 22.00	
23.00	Enter the locality adjustment national average per resident amount (see instructions)					0.00 23.00	
24.00	Multiply line 22 time line 23					0 24.00	
25.00	Total direct GME amount (sum of lines 19 and 24)					1,225,884 25.00	
		Inpatient Part A		Managed Care Prior to 1/1		Managed Care On or after 1/1	
		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)	20,236		2,265		4,461 26.00	
27.00	Total Inpatient Days (see instructions)	42,917		42,917		42,917 27.00	
28.00	Ratio of inpatient days to total inpatient days	0.471515		0.052776		0.103945 28.00	
29.00	Program direct GME amount	578,023		64,697		127,425 770,145 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			2,633		5,186 7,819 30.00	
31.00	Net Program direct GME amount					762,326 31.00	

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-3027	Period: From 09/01/2020 To 08/31/2021	Worksheet E-4 Date/Time Prepared: 1/25/2022 7:35 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)		1,230,478	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)		30,860,987	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)		30,860,987	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		20,646	42.00
43.00	Primary payer payments (see instructions)		0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		20,646	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		30,881,633	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.999331	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.000669	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		762,326	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		761,816	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		510	50.00

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

Provider CCN: 14-3027

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

Worksheet G

Date/Time Prepared:
1/25/2022 7:35 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	6,298,178	0	0	0	1.00
2.00 Temporary investments	0	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	9,391,207	0	0	0	4.00
5.00 Other receivable	102,559	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00 Inventory	73,724	0	0	0	7.00
8.00 Prepaid expenses	28,996	0	0	0	8.00
9.00 Other current assets	1,246,645	0	0	0	9.00
10.00 Due from other funds	17,860,891	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	35,002,200	0	0	0	11.00
FIXED ASSETS					
12.00 Land	6,800,000	0	0	0	12.00
13.00 Land improvements	0	0	0	0	13.00
14.00 Accumulated depreciation	0	0	0	0	14.00
15.00 Buildings	73,192,056	0	0	0	15.00
16.00 Accumulated depreciation	-17,243,974	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	0	0	0	0	19.00
20.00 Accumulated depreciation	0	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	8,810,158	0	0	0	23.00
24.00 Accumulated depreciation	-4,709,519	0	0	0	24.00
25.00 Minor equipment depreciable	0	0	0	0	25.00
26.00 Accumulated depreciation	0	0	0	0	26.00
27.00 HIT designated Assets	0	0	0	0	27.00
28.00 Accumulated depreciation	0	0	0	0	28.00
29.00 Minor equipment-nondepreciable	0	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	66,848,721	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	0	0	0	0	31.00
32.00 Deposits on leases	0	0	0	0	32.00
33.00 Due from owners/officers	0	0	0	0	33.00
34.00 Other assets	11,189,040	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	11,189,040	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	113,039,961	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	883,165	0	0	0	37.00
38.00 Salaries, wages, and fees payable	4,821,213	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	3,268,553	0	0	0	43.00
44.00 Other current liabilities	2,611,209	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	11,584,140	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	0	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	14,275,456	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	14,275,456	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	25,859,596	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	87,180,365				52.00
53.00 Specific purpose fund		0			53.00
54.00 Donor created - endowment fund balance - restricted			0		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)	87,180,365	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	113,039,961	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-3027

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

Worksheet G-1

Date/Time Prepared:
1/25/2022 7:35 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		86,506,735		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		558,080				2.00
3.00	Total (sum of line 1 and line 2)		87,064,815		0		3.00
4.00	NET CAPITAL RELEASE	115,548		0		0	4.00
5.00	ROUNDING	2		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		115,550		0		10.00
11.00	Subtotal (line 3 plus line 10)		87,180,365		0		11.00
12.00	INTERCOMPANY NET ASSETS SETTLEMENTS	0		0		0	12.00
13.00	ROUNDING	0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		87,180,365		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	NET CAPITAL RELEASE		0				4.00
5.00	ROUNDING		0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	INTERCOMPANY NET ASSETS SETTLEMENTS		0				12.00
13.00	ROUNDING		0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-3027

Period:
From 09/01/2020
To 08/31/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
1/25/2022 7:35 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	72,295,090		72,295,090	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				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	72,295,090		72,295,090	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	72,295,090		72,295,090	17.00
18.00	Ancillary services	80,361,213	516,607	80,877,820	18.00
19.00	Outpatient services	0	13,476,391	13,476,391	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER INCOME	421,502	0	421,502	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	153,077,805	13,992,998	167,070,803	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		87,627,420		29.00
30.00	ROUNDING	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	ROUNDING	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)		87,627,420		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-3027

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

Worksheet G-3

Date/Time Prepared:
1/25/2022 7:35 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	167,070,803	1.00
2.00	Less contractual allowances and discounts on patients' accounts	82,856,923	2.00
3.00	Net patient revenues (line 1 minus line 2)	84,213,880	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	87,627,420	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,413,540	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	899,225	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	452,433	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	403,510	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	1,931,132	24.00
24.50	COVID-19 PHE Funding	285,320	24.50
25.00	Total other income (sum of lines 6-24)	3,971,620	25.00
26.00	Total (line 5 plus line 25)	558,080	26.00
27.00	OTHER CONTRIBUTIONS	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	558,080	29.00