

Silver Cross Hospital

Medicare Cost Report

Provider # 14-0213



Medicaid Copy

FYE: September 30, 2020

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: 14-0213	Period: From 10/01/2019 To 09/30/2020	Worksheet S Parts I-III Date/Time Prepared: 4/29/2021 3:44 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 4/29/2021	Time: 3:44 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SILVER CROSS HOSPITAL (14-0213) for the cost reporting period beginning 10/01/2019 and ending 09/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Encryption Information

ECR: Date: 4/29/2021 Time: 3:44 pm

WLMJBVCd10CxfvFv3r6m3QhauUxA0

KdERT05eK5GZbnoZUhgJpp.g.HZTgh

ysYZ1m0gdf07f2zn

PI: Date: 4/29/2021 Time: 3:44 pm

oDw0TkoFgqz7:w8gwZaWIFn1Tq5cH0

02dM80hgb1yKqIPufbRqmbGKen1FCO

RDJP0p:nGn0UBmWw

(Signed) VINCENT PRYOR

Officer or Administrator of Provider(s)

EXECUTIVE VP & CFO

Title

04/30/2021 07:55:10 AM (PT)

Date

	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	-76,504	-171,417	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	63,761	0		0	3.00
4.00 SUBPROVIDER I						4.00
5.00 Swing Bed - SNF	0	0	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00 NURSING FACILITY	0				0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0		0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00 CMHC I	0		0		0	12.00
200.00 Total	0	-12,743	-171,417	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.

Health Financial Systems		SILVER CROSS HOSPITAL		In Lieu of Form CMS-2552-10						
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN:14-0213		Period: From 10/01/2019 To 09/30/2020		Worksheet S-2 Part I Date/Time Prepared: 4/29/2021 3:44 pm		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street:1900 SILVER CROSS BLVD.		PO Box:						1.00	
2.00	City: NEW LENOX		State: IL		Zip Code:60451		County:WILL		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		SILVER CROSS HOSPITAL	140213	16974	1	07/01/1966	N	P	P
4.00	Subprovider - IPF									
5.00	Subprovider - IRF		SCH - REHAB	14T213	16974	5	10/01/2000	N	P	P
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF									
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA		SCH HOME HEALTH	147452	16974		04/01/1994	N	P	N
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC									
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
17.10	Hospital-Based (CORF) I									
18.00	Renal Dialysis									
19.00	Other									
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					10/01/2019	09/30/2020		20.00	
21.00	Type of Control (see instructions)					1			21.00	
						1.00	2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	Y		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N		23.00	
			In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days		
			1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.		2,503	938	0	0	7,810	649	24.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN:14-0213		Period: From 10/01/2019 To 09/30/2020		Worksheet S-2 Part I Date/Time Prepared: 4/29/2021 3:44 pm	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	62	93	0	0	165			25.00
						Urban/Rural Status	Date of Geographic Reclassification		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00	
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00	
						V	XVIII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)						Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.						N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.								56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.								58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
				1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.					Y	Y		60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)						23.00	1	60.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet S-2
Part I
Date/Time Prepared:
4/29/2021 3:44 pm

	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section N 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)					61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)					61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)					61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).					61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)					61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)					61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
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
63.00	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" N for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					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.					
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet S-2
Part I
Date/Time Prepared:
4/29/2021 3:44 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		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
			1.00	2.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
					1.00	2.00	3.00
<u>Inpatient Psychiatric Facility PPS</u>							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N		70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N	0	71.00
<u>Inpatient Rehabilitation Facility PPS</u>							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N		75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N	0	76.00

Health Financial Systems		SILVER CROSS HOSPITAL		In Lieu of Form CMS-2552-10	
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			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N	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.			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	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	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	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			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	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	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	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	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	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)			N	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)			N	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
			1.00	2.00	3.00
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	109.00
			N	N	N
			N	N	N

Health Financial Systems		SILVER CROSS HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN:14-0213	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part I Date/Time Prepared: 4/29/2021 3:44 pm	
			1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N			110.00
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
			1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			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:	0	0	0	118.01
			1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §312N 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			120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	Removed and reserved				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00

Health Financial Systems		SILVER CROSS HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN:14-0213		Period: From 10/01/2019 To 09/30/2020	
				Worksheet S-2 Part I Date/Time Prepared: 4/29/2021 3:44 pm	
		1.00		2.00	
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)				HB2292
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: SILVER CROSS HOSPITAL HOME OFFICE		Contractor's Name: NGS		Contractor's Number: 06101
142.00	Street: 1900 SILVER CROSS BLVD.		PO Box:		
143.00	City: NEW LENOX		State: IL		Zip Code: 60451
		1.00			
144.00	Are provider based physicians' costs included in Worksheet A?				Y
		1.00		2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				Y
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.				
		1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N
		Part A		Part B	
		1.00		2.00	
		Title V		Title XIX	
		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
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N
161.10	CORF		N	N	N
		1.00			
Multicampus					
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N
		Name		County	
		0		1.00	
		State		Zip Code	
		2.00		3.00	
		CBSA		FTE/Campus	
		4.00		5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)				0.00
		1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act					
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.				Y
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)				
168.01	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)				
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)				9.99

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN:14-0213	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part I Date/Time Prepared: 4/29/2021 3:44 pm
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)			171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN:14-0213	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part II Date/Time Prepared: 4/29/2021 3:44 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
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 2.00	V/I 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.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the 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.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current 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 Y/N 1.00	Part B Y/N 3.00
			Date 2.00	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	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	02/04/2021	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N	N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N	N	19.00

Health Financial Systems		SILVER CROSS HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN:14-0213		Period: From 10/01/2019 To 09/30/2020	
		Worksheet S-2 Part II Date/Time Prepared: 4/29/2021 3:44 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?	Y			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.	Y			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.	N			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N			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.	RAY	NOVAK		41.00
42.00	Enter the employer/company name of the cost report preparer	SILVER CROSS HOSPITAL			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	815-300-7029	KNOVAK@SILVERCROSS.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet S-2
Part II
Date/Time Prepared:
4/29/2021 3:44 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.	CONTROLLER	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:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
4/29/2021 3:44 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	245	89,174	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)		245	89,174	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	30	10,980	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT	33.00	0	0	0.00	0	10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		275	100,154	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00 SUBPROVIDER - IRF	41.00	25	9,150		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00 NURSING FACILITY	45.00	0	0		0	20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC	99.00				0	25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		300				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:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
4/29/2021 3:44 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)	26,028	2,723	61,219			1.00
2.00 HMO and other (see instructions)	10,135	7,810				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	968	165				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)	26,028	2,723	61,219			7.00
8.00 INTENSIVE CARE UNIT	4,091	394	8,850			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT	0	0	0			10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		324	7,289			13.00
14.00 Total (see instructions)	30,119	3,441	77,358	0.00	1,823.31	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00 SUBPROVIDER - IRF	5,375	155	8,355	0.00	53.48	17.00
18.00 SUBPROVIDER		0	0	0.00	0.00	18.00
19.00 SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00 NURSING FACILITY		0	0	0.00	0.00	20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	12,837	0	26,350	0.00	33.02	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	0	0	0	0.00	0.00	25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00 RURAL HEALTH CLINIC	0	0	0	0.00	0.00	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)				0.00	1,909.81	27.00
28.00 Observation Bed Days		1,458	9,361			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	649	1,910			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:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
4/29/2021 3:44 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	6,831	1,219	18,951	1.00
2.00 HMO and other (see instructions)			2,123	2,501		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				13		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	6,831	1,219	18,951	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00 SUBPROVIDER - IRF	0.00	0	433	14	700	17.00
18.00 SUBPROVIDER	0.00	0		0	0	18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY	0.00					20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC	0.00					25.00
25.10 CMHC - CORF	0.00					25.10
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part II
Date/Time Prepared:
4/29/2021 3:44 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	138,716,577	0	138,716,577	3,972,564.80	34.92
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		7,519,979	0	7,519,979	188,394.40	39.92
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,033,272	0	2,033,272	28,221.64	72.05
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		761,585	0	761,585	4,195.00	181.55
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		6,031,680	0	6,031,680	17,688.00	341.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		36,084,601	0	36,084,601		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		2,068,312	0	2,068,312		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part II
Date/Time Prepared:
4/29/2021 3:44 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	1,089,286	0	1,089,286	28,034.40	38.86	26.00
27.00	Administrative & General	5.00	19,868,051	-27,488	19,840,563	603,836.10	32.86	27.00
28.00	Administrative & General under contract (see inst.)		838,951	0	838,951	11,882.74	70.60	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	3,464,459	0	3,464,459	130,484.80	26.55	30.00
31.00	Laundry & Linen Service	8.00	70,799	0	70,799	4,321.60	16.38	31.00
32.00	Housekeeping	9.00	2,811,457	0	2,811,457	170,402.40	16.50	32.00
33.00	Housekeeping under contract (see instructions)		57,796	0	57,796	2,920.05	19.79	33.00
34.00	Dietary	10.00	2,216,805	-1,617,948	598,857	35,794.97	16.73	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,617,948	1,617,948	96,708.23	16.73	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	3,402,369	0	3,402,369	75,809.60	44.88	38.00
39.00	Central Services and Supply	14.00	1,700,811	-967,349	733,462	37,584.80	19.51	39.00
40.00	Pharmacy	15.00	4,006,078	0	4,006,078	83,692.80	47.87	40.00
41.00	Medical Records & Medical Records Library	16.00	2,837,555	0	2,837,555	91,472.80	31.02	41.00
42.00	Social Service	17.00	0	27,488	27,488	731.10	37.60	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part III
Date/Time Prepared:
4/29/2021 3:44 pm

	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	139,613,324	0	139,613,324	3,987,367.59	35.01	1.00
2.00	Excluded area salaries (see instructions)	7,519,979	0	7,519,979	188,394.40	39.92	2.00
3.00	Subtotal salaries (line 1 minus line 2)	132,093,345	0	132,093,345	3,798,973.19	34.77	3.00
4.00	Subtotal other wages & related costs (see inst.)	8,826,537	0	8,826,537	50,104.64	176.16	4.00
5.00	Subtotal wage-related costs (see inst.)	36,084,601	0	36,084,601	0.00	27.32	5.00
6.00	Total (sum of lines 3 thru 5)	177,004,483	0	177,004,483	3,849,077.83	45.99	6.00
7.00	Total overhead cost (see instructions)	42,364,417	-967,349	41,397,068	1,373,676.39	30.14	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part IV
Date/Time Prepared:
4/29/2021 3:44 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	9,439,646	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	7,436,013	8.02
8.03	Health Insurance (Purchased)	7,201,914	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	594,683	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	158,448	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	765,915	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	682,926	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	10,319,173	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	1,420,459	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	133,736	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	38,152,913	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part V
Date/Time Prepared:
4/29/2021 3:44 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	2,033,272	38,152,913	1.00
2.00	Hospital	2,033,272	38,152,913	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC	0	0	16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

Health Financial Systems		SILVER CROSS HOSPITAL			In Lieu of Form CMS-2552-10				
HOME HEALTH AGENCY STATISTICAL DATA				Provider CCN:14-0213 Component CCN:14-7452		Period: From 10/01/2019 To 09/30/2020		Worksheet S-4 Date/Time Prepared: 4/29/2021 3:44 pm	
				Home Health Agency I		PPS			
				1.00					
0.00 County				WILL		0.00			
				Title V	Title XVIII	Title XIX	Other	Total	
				1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA									
1.00	Home Health Aide Hours	0	2,149	15	542	2,706	1.00		
2.00	Unduplicated Census Count (see instructions)	0.00	706.00	53.00	1,176.00	1,935.00	2.00		
				Number of Employees (Full Time Equivalent)					
		Enter the number of hours in your normal work week		Staff	Contract	Total			
		0		1.00	2.00	3.00			
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES									
3.00	Administrator and Assistant Administrator(s)	40.00	9.89	0.00	9.89	3.00			
4.00	Director(s) and Assistant Director(s)		0.00	0.00	0.00	4.00			
5.00	Other Administrative Personnel		0.00	0.00	0.00	5.00			
6.00	Direct Nursing Service		13.60	0.00	13.60	6.00			
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00			
8.00	Physical Therapy Service		5.35	2.57	7.92	8.00			
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00			
10.00	Occupational Therapy Service		2.02	0.00	2.02	10.00			
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00			
12.00	Speech Pathology Service		0.33	0.00	0.33	12.00			
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00			
14.00	Medical Social Service		0.02	0.00	0.02	14.00			
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00			
16.00	Home Health Aide		1.14	0.00	1.14	16.00			
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00			
18.00	SOCIAL WORKER/REHAB REP		0.21	0.00	0.21	18.00			
HOME HEALTH AGENCY CBSA CODES									
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		1			19.00			
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		16974			20.00			
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)			
		Without Outliers	With Outliers						
		1.00	2.00	3.00	4.00	5.00			
PPS ACTIVITY DATA									
21.00	Skilled Nursing Visits	5,018	392	214	103	5,727	21.00		
22.00	Skilled Nursing Visit Charges	1,209,057	94,394	45,270	24,802	1,373,523	22.00		
23.00	Physical Therapy Visits	3,465	374	57	85	3,981	23.00		
24.00	Physical Therapy Visit Charges	778,784	84,449	8,355	19,193	890,781	24.00		
25.00	Occupational Therapy Visits	1,311	307	10	24	1,652	25.00		
26.00	Occupational Therapy Visit Charges	293,314	69,321	677	3,839	367,151	26.00		
27.00	Speech Pathology Visits	141	54	0	0	195	27.00		
28.00	Speech Pathology Visit Charges	32,113	12,941	0	0	45,054	28.00		
29.00	Medical Social Service Visits	23	5	2	1	31	29.00		
30.00	Medical Social Service Visit Charges	7,584	1,649	660	330	10,223	30.00		
31.00	Home Health Aide Visits	522	79	7	7	615	31.00		
32.00	Home Health Aide Visit Charges	76,865	11,633	1,031	1,031	90,560	32.00		
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	10,480	1,211	290	220	12,201	33.00		
34.00	Other Charges	0	0	0	0	0	34.00		
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	2,397,717	274,387	55,993	49,195	2,777,292	35.00		
36.00	Total Number of Episodes (standard/non outlier)	835		117	25	977	36.00		
37.00	Total Number of Outlier Episodes		48		1	49	37.00		
38.00	Total Non-Routine Medical Supply Charges	0	0	0	0	0	38.00		

Health Financial Systems		SILVER CROSS HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN:14-0213	Period: From 10/01/2019 To 09/30/2020	Worksheet S-10 Date/Time Prepared: 4/29/2021 3:44 pm	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.286961	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			29,988,675	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			120,656,680	6.00
7.00	Medicaid cost (line 1 times line 6)			34,623,762	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			4,635,087	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP			0	9.00
10.00	Stand-alone CHIP charges			0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12, 16 and 17)			8,410,35,087	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	15,574,479	4,812,969	20,387,448	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	4,469,268	4,812,969	9,282,237	21.00
22.00	Payments received from patients for amounts previously written off as charity care	63,692	258,433	322,125	22.00
23.00	Cost of charity care (line 21 minus line 22)	4,405,576	4,554,536	8,960,112	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			15,645,944	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			876,471	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			1,348,416	27.01
28.00	Non-Medicare bad debt expense (see instructions)			14,297,528	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			4,574,778	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			13,534,890	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			18,169,977	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN:14-0213

Period:

From 10/01/2019

To 09/30/2020

Worksheet A

Date/Time Prepared:

4/29/2021 3:44 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		48,993,745	48,993,745	-20,913,257	28,080,488	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	16,257,325	16,257,325	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,089,286	38,751,373	39,840,659	-3,004	39,837,655	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	19,868,051	59,451,577	79,319,628	-2,059,954	77,259,674	5.00
7.00	00700	OPERATION OF PLANT	3,464,459	6,961,309	10,425,768	-11,947	10,413,821	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	70,799	183,587	254,386	0	254,386	8.00
9.00	00900	HOUSEKEEPING	2,811,457	1,546,808	4,358,265	-56,478	4,301,787	9.00
10.00	01000	DIETARY	2,216,805	2,310,908	4,527,713	-3,318,635	1,209,078	10.00
11.00	01100	CAFETERIA	0	0	0	3,304,578	3,304,578	11.00
13.00	01300	NURSING ADMINISTRATION	3,402,369	37,755	3,440,124	-4,662	3,435,462	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,700,811	1,798,088	3,498,899	-2,581,526	917,373	14.00
15.00	01500	PHARMACY	4,006,078	16,294,267	20,300,345	-13,890,539	6,409,806	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,837,555	374,160	3,211,715	-1,016	3,210,699	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	27,488	27,488	17.00
23.00	02300	PARAMED ED PRGM	286,648	410,981	697,629	-132,179	565,450	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	27,139,009	4,123,894	31,262,903	2,858,587	34,121,490	30.00
31.00	03100	INTENSIVE CARE UNIT	7,809,101	1,847,418	9,656,519	-483,609	9,172,910	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	4,169,853	668,057	4,837,910	-46,389	4,791,521	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	10,105,450	810,842	10,916,292	-8,098,549	2,817,743	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,919,932	39,213,953	49,133,885	-27,708,278	21,425,607	50.00
51.00	05100	RECOVERY ROOM	1,399,413	104,300	1,503,713	-41,907	1,461,806	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	948,684	948,684	3,706,005	4,654,689	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,341,767	17,861,847	26,203,614	-13,316,154	12,887,460	54.00
54.01	05401	ULTRASOUND	1,247,179	331,564	1,578,743	-70,854	1,507,889	54.01
57.00	05700	CT SCAN	1,281,024	1,215,328	2,496,352	-235,216	2,261,136	57.00
58.00	05800	MRI	711,630	479,692	1,191,322	-26,057	1,165,265	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	4,528,812	8,413,097	12,941,909	-1,726,234	11,215,675	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	255,348	1,533,793	1,789,141	-48,973	1,740,168	63.00
65.00	06500	RESPIRATORY THERAPY	2,201,840	528,777	2,730,617	16,320	2,746,937	65.00
65.01	06501	SLEEP LAB	213,763	167,358	381,121	103,391	484,512	65.01
66.00	06600	PHYSICAL THERAPY	1,436,901	327,319	1,764,220	-2,222	1,761,998	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,484,924	400,620	1,885,544	-13,088	1,872,456	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,426,522	208,496	1,635,018	944,549	2,579,567	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	152,534	27,564	180,098	1,457,447	1,637,545	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	29,207,058	29,207,058	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	278	278	23,867,901	23,868,179	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,807,162	13,807,162	73.00
74.00	07400	RENAL DIALYSIS	493,180	191,953	685,133	-98,954	586,179	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	640,167	222,472	862,639	17,793	880,432	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMENS HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	8,634,510	2,685,864	11,320,374	-641,928	10,678,446	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	305,922	3,304	309,226	-54,311	254,915	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	3,050,330	600,043	3,650,373	10,316	3,660,689	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	138,703,429	260,031,075	398,734,504	0	398,734,504	118.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020

Worksheet A

Date/Time Prepared:
4/29/2021 3:44 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	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	13,148	0	13,148	0	13,148	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	138,716,577	260,031,075	398,747,652	0	398,747,652	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020

Worksheet A

Date/Time Prepared:
4/29/2021 3:44 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-16,835,377	11,245,111	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	16,257,325	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-81,526	39,756,129	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-20,062,941	57,196,733	5.00
7.00	00700	OPERATION OF PLANT	-202	10,413,619	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	254,386	8.00
9.00	00900	HOUSEKEEPING	-6	4,301,781	9.00
10.00	01000	DIETARY	-14,300	1,194,778	10.00
11.00	01100	CAFETERIA	-1,749,225	1,555,353	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,435,462	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	917,373	14.00
15.00	01500	PHARMACY	-2,702	6,407,104	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,651	3,208,048	16.00
17.00	01700	SOCIAL SERVICE	0	27,488	17.00
23.00	02300	PARAMED ED PRGM	-169,369	396,081	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,963,551	32,157,939	30.00
31.00	03100	INTENSIVE CARE UNIT	-565,951	8,606,959	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	-108,754	4,682,767	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	-2,167	2,815,576	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-302,040	21,123,567	50.00
51.00	05100	RECOVERY ROOM	0	1,461,806	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,654,689	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-88,307	12,799,153	54.00
54.01	05401	ULTRASOUND	0	1,507,889	54.01
57.00	05700	CT SCAN	0	2,261,136	57.00
58.00	05800	MRI	0	1,165,265	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-80,736	11,134,939	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	1,740,168	63.00
65.00	06500	RESPIRATORY THERAPY	-72,129	2,674,808	65.00
65.01	06501	SLEEP LAB	-110,000	374,512	65.01
66.00	06600	PHYSICAL THERAPY	0	1,761,998	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,872,456	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	-1,152,797	1,426,770	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-1,461,125	176,420	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	29,207,058	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	23,868,179	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,807,162	73.00
74.00	07400	RENAL DIALYSIS	-4,466	581,713	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	-90,767	789,665	90.00
90.01	09001	HOMER GLEN LAB	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	90.02
90.03	09003	WOMENS HEALTH	0	0	90.03
91.00	09100	EMERGENCY	-747,411	9,931,035	91.00
91.01	09101	OP MENTAL HEALTH	0	0	91.01
91.02	09102	DIABETES CENTER	0	254,915	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0	0	94.00
99.00	09900	CMHC	0	0	99.00
99.10	09910	CORF	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	3,660,689	101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-45,668,500	353,066,004	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	13,148	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	192.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN:14-0213	Period: From 10/01/2019 To 09/30/2020	Worksheet A Date/Time Prepared: 4/29/2021 3:44 pm
Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
200.00	TOTAL (SUM OF LINES 118 through 199)	-45,668,500	353,079,152	200.00	

Increases					
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
A - STERILE PROCESSING					
1.00 ADULTS & PEDIATRICS	30.00	13,543	20,774		1.00
2.00 OPERATING ROOM	50.00	866,745	1,329,524		2.00
3.00 DELIVERY ROOM & LABOR ROOM	52.00	60,943	93,482		3.00
4.00 RADIOLOGY-DIAGNOSTIC	54.00	6,771	10,387		4.00
5.00 CLINIC	90.00	3,869	5,935		5.00
6.00 EMERGENCY	91.00	15,478	23,742		6.00
0		967,349	1,483,844		
C - CAPITAL INSURANCE					
1.00 CAP REL COSTS-MVBLE EQUIP	2.00	0	228,846		1.00
2.00 ADMINISTRATIVE & GENERAL	5.00	0	253,136		2.00
0		0	481,982		
D - CHARGEABLE DRUGS					
1.00 DRUGS CHARGED TO PATIENTS	73.00	0	13,807,162		1.00
2.00	0.00	0	0		2.00
3.00	0.00	0	0		3.00
0		0	13,807,162		
E - MALPRACTICE INSURANCE					
1.00 ADMINISTRATIVE & GENERAL	5.00	0	4,402,796		1.00
0		0	4,402,796		
F - DEPRECIATION					
1.00 CAP REL COSTS-MVBLE EQUIP	2.00	0	16,028,479		1.00
0		0	16,028,479		
G - PHYSICIAN FEES					
1.00 ADULTS & PEDIATRICS	30.00	0	2,009,810		1.00
2.00 INTENSIVE CARE UNIT	31.00	0	602,031		2.00
3.00 SUBPROVIDER - IRF	41.00	0	108,754		3.00
4.00 OPERATING ROOM	50.00	0	369,936		4.00
5.00 RADIOLOGY-DIAGNOSTIC	54.00	0	106,500		5.00
6.00 LABORATORY	60.00	0	150,000		6.00
7.00 RESPIRATORY THERAPY	65.00	0	85,332		7.00
8.00 SLEEP LAB	65.01	0	110,000		8.00
9.00 ELECTROCARDIOLOGY	69.00	0	1,162,456		9.00
10.00 ELECTROENCEPHALOGRAPHY	70.00	0	1,470,667		10.00
11.00 RENAL DIALYSIS	74.00	0	10,600		11.00
12.00 CLINIC	90.00	0	91,875		12.00
13.00 EMERGENCY	91.00	0	625,050		13.00
14.00 DIABETES CENTER	91.02	0	5,004		14.00
15.00 HOME HEALTH AGENCY	101.00	0	32,008		15.00
0		0	6,940,023		
H - LABOR AND DELIVERY					
1.00 ADULTS & PEDIATRICS	30.00	3,669,705	0		1.00
2.00 DELIVERY ROOM & LABOR ROOM	52.00	4,276,251	0		2.00
0		7,945,956	0		
I - SOCIAL SERVICES					
1.00 SOCIAL SERVICE	17.00	27,488	0		1.00
0		27,488	0		
K - CHARGEABLE SUPPLIES					
1.00 ADMINISTRATIVE & GENERAL	5.00	0	257,905		1.00
2.00 MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	29,207,058		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
23.00	0.00	0	0		23.00
24.00	0.00	0	0		24.00
25.00	0.00	0	0		25.00

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
0			0	29,464,963		
L - DIABETES MANAGEMENT						
1.00	ADULTS & PEDIATRICS	30.00	58,473	632		1.00
0			58,473	632		
M - DIETARY RECLASS						
1.00	CAFETERIA	11.00	1,617,948	1,686,630		1.00
0			1,617,948	1,686,630		
N - IMPLANTABLE DEVICES						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	23,867,901		1.00
2.00		0.00	0	0		
0			0	23,867,901		
500.00	Grand Total: Increases		10,617,214	98,164,412		500.00

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - STERILE PROCESSING							
1.00	CENTRAL SERVICES & SUPPLY	14.00	967,349	1,483,844	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	0		967,349	1,483,844			
C - CAPITAL INSURANCE							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	481,982	12		1.00
2.00		0.00	0	0	0		2.00
	0		0	481,982			
D - CHARGEABLE DRUGS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,280	0		1.00
2.00	BLOOD STORING PROCESSING & TRANS.	63.00	0	3,919	0		2.00
3.00	PHARMACY	15.00	0	13,796,963	0		3.00
	0		0	13,807,162			
E - MALPRACTICE INSURANCE							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,402,796	12		1.00
	0		0	4,402,796			
F - DEPRECIATION							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	16,028,479	9		1.00
	0		0	16,028,479			
G - PHYSICIAN FEES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,940,023	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
	0		0	6,940,023			
H - LABOR AND DELIVERY							
1.00	NURSERY	43.00	7,945,956	0	0		1.00
2.00		0.00	0	0	0		2.00
	0		7,945,956	0			
I - SOCIAL SERVICES							
1.00	ADMINISTRATIVE & GENERAL	5.00	27,488	0	0		1.00
	0		27,488	0			
K - CHARGEABLE SUPPLIES							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,004	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	130,333	0		2.00
3.00	PHARMACY	15.00	0	93,576	0		3.00
4.00	PARAMED ED PRGM	23.00	0	132,179	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	2,914,350	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	1,085,640	0		6.00
7.00	SUBPROVIDER - IRF	41.00	0	155,143	0		7.00
8.00	NURSERY	43.00	0	152,593	0		8.00
9.00	OPERATING ROOM	50.00	0	12,995,758	0		9.00
10.00	RECOVERY ROOM	51.00	0	41,907	0		10.00
11.00	DELIVERY ROOM & LABOR ROOM	52.00	0	724,671	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6,850,636	0		12.00
13.00	ULTRASOUND	54.01	0	70,854	0		13.00
14.00	CT SCAN	57.00	0	235,216	0		14.00
15.00	LABORATORY	60.00	0	1,876,234	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	69,012	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	2,222	0		17.00
18.00	OCCUPATIONAL THERAPY	67.00	0	13,088	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	0	217,907	0		19.00
20.00	ELECTROENCEPHALOGRAPHY	70.00	0	13,220	0		20.00
21.00	RENAL DIALYSIS	74.00	0	109,554	0		21.00
22.00	CLINIC	90.00	0	83,886	0		22.00
23.00	EMERGENCY	91.00	0	1,306,198	0		23.00
24.00	DIABETES CENTER	91.02	0	210	0		24.00
25.00	HOME HEALTH AGENCY	101.00	0	21,692	0		25.00

	Decreases				Wkst. A-7 Ref.		
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00	10.00		
26.00	OPERATION OF PLANT	7.00	0	11,947	0		26.00
27.00	HOUSEKEEPING	9.00	0	56,478	0		27.00
28.00	DIETARY	10.00	0	14,057	0		28.00
29.00	NURSING ADMINISTRATION	13.00	0	4,662	0		29.00
30.00	SLEEP LAB	65.01	0	6,609	0		30.00
31.00	BLOOD STORING PROCESSING & TRANS.	63.00	0	45,054	0		31.00
32.00	MRI	58.00	0	26,057	0		32.00
33.00	MEDICAL RECORDS & LIBRARY	16.00	0	1,016	0		33.00
			0	29,464,963			
	L - DIABETES MANAGEMENT						
1.00	DIABETES CENTER	91.02	58,473	632	0		1.00
			58,473	632			
	M - DIETARY RECLASS						
1.00	DIETARY	10.00	1,617,948	1,686,630	0		1.00
			1,617,948	1,686,630			
	N - IMPLANTABLE DEVICES						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6,589,176	0		1.00
2.00	OPERATING ROOM	50.00	0	17,278,725	0		2.00
			0	23,867,901			
500.00	Grand Total: Decreases		10,617,214	98,164,412			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part I
Date/Time Prepared:
4/29/2021 3:44 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	20,472,804	0	0	0	421,990	1.00
2.00	Land Improvements	16,134,861	1,184,508	0	1,184,508	0	2.00
3.00	Buildings and Fixtures	336,202,437	9,314,493	0	9,314,493	0	3.00
4.00	Building Improvements	40,719,446	2,863,929	0	2,863,929	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	221,698,295	14,481,370	0	14,481,370	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	635,227,843	27,844,300	0	27,844,300	421,990	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	635,227,843	27,844,300	0	27,844,300	421,990	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
		PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES					
1.00	Land	20,050,814	0				1.00
2.00	Land Improvements	17,319,369	0				2.00
3.00	Buildings and Fixtures	345,516,930	0				3.00
4.00	Building Improvements	43,583,375	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	236,179,665	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	662,650,153	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	662,650,153	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part II
Date/Time Prepared:
4/29/2021 3:44 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	28,731,842	23,200	14,927,639	5,080,925	230,139	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	28,731,842	23,200	14,927,639	5,080,925	230,139	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum 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	48,993,745				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	48,993,745				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part III
Date/Time Prepared:
4/29/2021 3:44 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	426,470,488	0	426,470,488	0.643583	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	236,179,665	0	236,179,665	0.356417	0	2.00
3.00	Total (sum of lines 1-2)	662,650,153	0	662,650,153	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	10,795,625	23,200	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	16,028,479	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	26,824,104	23,200	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	196,147	230,139	0	11,245,111	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	228,846	0	0	16,257,325	2.00
3.00	Total (sum of lines 1-2)	0	424,993	230,139	0	27,502,436	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-8

Date/Time Prepared:
4/29/2021 3:44 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #	Wkst. A-7 Ref.
				3.00	4.00		
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	-6,556,319				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	-1,349,895				0 12.00
13.00	Laundry and linen service		0		0.00		0 13.00
14.00	Cafeteria-employees and guests		0		0.00		0 14.00
15.00	Rental of quarters to employees and others		0		0.00		0 15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00		0 16.00
17.00	Sale of drugs to other than patients		0		0.00		0 17.00
18.00	Sale of medical records and abstracts		0		0.00		0 18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00		0 19.00
20.00	Vending machines		0		0.00		0 20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00		0 21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00		0 22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0CAP REL COSTS-BLDG & FIXT	1.00		0 26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00		0 27.00
28.00	Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00		0 29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00		0 32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (8)		0		0.00		0 33.00

ADJUSTMENTS TO EXPENSES

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-8

Date/Time Prepared:
4/29/2021 3:44 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	
33.01 1996 DSR INTEXP	A	14,351	CAP REL COSTS-BLDG & FIXT	1.00	9	33.01
33.02 PHYSICIANS	A	-54,977	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03 CONTRIBUTIONS EXPENSE	B	-162,003	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04 BAD DEBTS	A	477,480	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05 TELEPHONE BENEFITS	B	-20,385	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.05
33.06 TELEPHONE COSTS	A	-76,370	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07 COMMUNITY RELATIONS	A	-1,357,030	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08 OTHER REV - CAPITAL EXPENSE	B	-1,922,089	CAP REL COSTS-BLDG & FIXT	1.00	9	33.08
33.09 OTHER REV - EMPLOYEE BENEFIS	B	-61,141	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.09
33.10 OTHER REV A & G	B	-711,538	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11 OTHER REV - OPERATION & PLANT	B	-202	OPERATION OF PLANT	7.00	0	33.11
33.12 OTHER REV - PHARMACY	B	-2,702	PHARMACY	15.00	0	33.12
33.13 OTHER REV - MED REC	B	-2,651	MEDICAL RECORDS & LIBRARY	16.00	0	33.13
33.14 OTHER REV - PARAMED ED PROGRAM	B	-169,369	PARAMED ED PRGM	23.00	0	33.14
33.15 OTHER REV - NURSERY	B	-2,167	NURSERY	43.00	0	33.15
33.16 OTHER REV - OPERATING ROOM	B	-2	OPERATING ROOM	50.00	0	33.16
33.17 OTHER REV - RADIOLOGY	B	-6,428	RADIOLOGY-DIAGNOSTIC	54.00	0	33.17
33.18 OTHER REV - LAB	B	-2,298	LABORATORY	60.00	0	33.18
33.19 OTHER REV - CARDIAC CATH	B	-14,365	ELECTROCARDIOLOGY	69.00	0	33.19
33.20 OTHER REV - ER	B	-168,620	EMERGENCY	91.00	0	33.20
33.21 INVESTMENT INCOME	B	-14,927,639	CAP REL COSTS-BLDG & FIXT	1.00	11	33.21
33.22 AHA & IHA DUES-POLITICAL LOBBY	B	-47,530	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.23 PROVIDER TAX ASSESSMENT IN A&G	A	-16,624,869	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24 ADMIN MISC	A	-156,209	ADMINISTRATIVE & GENERAL	5.00	0	33.24
33.25 OTHER REV - NUTRITION	B	-14,300	DIETARY	10.00	0	33.25
33.26 OTHER REV - HOUSEKEEPING	B	-6	HOUSEKEEPING	9.00	0	33.26
33.27 OTHER REV - CAFETERIA	B	-1,749,225	CAFETERIA	11.00	0	33.27
33.28 OTHER REV - RESP THERAPY	B	-2	RESPIRATORY THERAPY	65.00	0	33.28
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-45,668,500				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:14-0213

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-8-1

Date/Time Prepared:
4/29/2021 3:44 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	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEE	7,287,741	8,637,636	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	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			7,287,741	8,637,636	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 costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	G	SILVER CROSS HO	100.00	SILVER CROSS HO	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	FINANCIAL				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:14-0213	Period: From 10/01/2019 To 09/30/2020	Worksheet A-8-1 Date/Time Prepared: 4/29/2021 3:44 pm
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	Net Adjustment (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	-1,349,895	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-1,349,895			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 costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	HOME OFFICE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-8-2

Date/Time Prepared:
4/29/2021 3:44 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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	211,500	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	2,009,810	1,864,386	145,424	177,200	543	2.00
3.00	31.00	INTENSIVE CARE UNIT	602,031	542,031	60,000	154,100	487	3.00
4.00	40.00	SUBPROVIDER - IPF	0	0	0	154,100	0	4.00
5.00	41.00	SUBPROVIDER - IRF	108,754	108,754	0	208,000	0	5.00
6.00	50.00	OPERATING ROOM	369,936	284,586	85,350	177,200	797	6.00
7.00	65.00	RESPIRATORY THERAPY	85,332	70,000	15,332	177,200	155	7.00
8.00	69.00	ELECTROCARDIOLOGY	1,162,456	1,122,456	40,000	177,200	282	8.00
9.00	70.00	ELECTROENCEPHALOGRAPHY	1,470,667	1,424,167	46,500	177,200	112	9.00
10.00	74.00	RENAL DIALYSIS	10,600	0	10,600	177,200	72	10.00
11.00	90.00	CLINIC	91,875	90,000	1,875	177,200	13	11.00
12.00	91.00	EMERGENCY	625,050	530,050	95,000	177,200	543	12.00
13.00	65.01	SLEEP LAB	110,000	110,000	0	215,700	0	13.00
14.00	60.00	LABORATORY	150,000	0	150,000	177,200	840	14.00
15.00	91.02	DIABETES CENTER	5,004	0	5,004	177,200	62	15.00
16.00	54.00	RADIOLOGY-DIAGNOSTIC	106,500	0	106,500	177,200	289	16.00
200.00			6,908,015	6,146,430	761,585		4,195	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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	46,259	2,313	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	36,080	1,804	0	0	0	3.00
4.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	4.00
5.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	5.00
6.00	50.00	OPERATING ROOM	67,898	3,395	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	13,205	660	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	24,024	1,201	0	0	0	8.00
9.00	70.00	ELECTROENCEPHALOGRAPHY	9,542	477	0	0	0	9.00
10.00	74.00	RENAL DIALYSIS	6,134	307	0	0	0	10.00
11.00	90.00	CLINIC	1,108	55	0	0	0	11.00
12.00	91.00	EMERGENCY	46,259	2,313	0	0	0	12.00
13.00	65.01	SLEEP LAB	0	0	0	0	0	13.00
14.00	60.00	LABORATORY	71,562	3,578	0	0	0	14.00
15.00	91.02	DIABETES CENTER	5,282	264	0	0	0	15.00
16.00	54.00	RADIOLOGY-DIAGNOSTIC	24,621	1,231	0	0	0	16.00
200.00			351,974	17,598	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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	46,259	99,165	1,963,551		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	36,080	23,920	565,951		3.00
4.00	40.00	SUBPROVIDER - IPF	0	0	0	0		4.00
5.00	41.00	SUBPROVIDER - IRF	0	0	0	108,754		5.00
6.00	50.00	OPERATING ROOM	0	67,898	17,452	302,038		6.00
7.00	65.00	RESPIRATORY THERAPY	0	13,205	2,127	72,127		7.00
8.00	69.00	ELECTROCARDIOLOGY	0	24,024	15,976	1,138,432		8.00
9.00	70.00	ELECTROENCEPHALOGRAPHY	0	9,542	36,958	1,461,125		9.00
10.00	74.00	RENAL DIALYSIS	0	6,134	4,466	4,466		10.00
11.00	90.00	CLINIC	0	1,108	767	90,767		11.00
12.00	91.00	EMERGENCY	0	46,259	48,741	578,791		12.00
13.00	65.01	SLEEP LAB	0	0	0	110,000		13.00
14.00	60.00	LABORATORY	0	71,562	78,438	78,438		14.00
15.00	91.02	DIABETES CENTER	0	5,282	0	0		15.00
16.00	54.00	RADIOLOGY-DIAGNOSTIC	0	24,621	81,879	81,879		16.00
200.00			0	351,974	409,889	6,556,319		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet B
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	11,245,111	11,245,111			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	16,257,325		16,257,325		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	39,756,129	41,668	0	39,797,797	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	57,196,733	2,584,660	9,947,132	5,737,315	5.00
7.00	00700	OPERATION OF PLANT	10,413,619	138,358	102,280	1,001,821	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	254,386	47,592	0	20,473	8.00
9.00	00900	HOUSEKEEPING	4,301,781	117,988	3,190	812,992	9.00
10.00	01000	DIETARY	1,194,778	468,919	4,855	173,172	10.00
11.00	01100	CAFETERIA	1,555,353	0	13,117	467,864	11.00
13.00	01300	NURSING ADMINISTRATION	3,435,462	59,355	71,632	983,866	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	917,373	378,380	166,689	212,096	14.00
15.00	01500	PHARMACY	6,407,104	156,190	42,632	1,158,442	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,208,048	22,103	1,650	820,539	16.00
17.00	01700	SOCIAL SERVICE	27,488	0	0	7,949	17.00
23.00	02300	PARAMED ED PRGM	396,081	17,295	15,574	82,890	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	32,157,939	2,723,927	336,478	8,929,786	30.00
31.00	03100	INTENSIVE CARE UNIT	8,606,959	350,395	187,945	2,258,166	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	4,682,767	416,230	17,693	1,205,801	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	2,815,576	939,552	40,370	624,463	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	21,123,567	1,133,035	2,863,551	3,119,194	50.00
51.00	05100	RECOVERY ROOM	1,461,806	89,508	345	404,670	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,654,689	0	90,675	1,254,191	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,799,153	505,924	1,254,486	2,414,155	54.00
54.01	05401	ULTRASOUND	1,507,889	61,956	21,467	360,648	54.01
57.00	05700	CT SCAN	2,261,136	55,579	325,618	370,435	57.00
58.00	05800	MRI	1,165,265	71,656	24,598	205,783	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	11,134,939	12,362	203,850	1,309,601	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	1,740,168	0	12,096	73,839	63.00
65.00	06500	RESPIRATORY THERAPY	2,674,808	40,554	53,540	636,708	65.00
65.01	06501	SLEEP LAB	374,512	0	1,625	61,814	65.01
66.00	06600	PHYSICAL THERAPY	1,761,998	5,139	2,018	415,510	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,872,456	0	28,846	429,397	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,426,770	30,049	179,303	412,509	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	176,420	21,464	19,434	44,108	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	29,207,058	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,868,179	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,807,162	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	581,713	59,768	7,932	142,613	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	789,665	0	2,162	186,237	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	90.02
90.03	09003	WOMENS HEALTH	0	0	0	0	90.03
91.00	09100	EMERGENCY	9,931,035	658,171	213,184	2,501,326	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	254,915	0	271	71,555	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	3,660,689	0	1,087	882,067	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	353,066,004	11,207,777	16,257,325	39,793,995	353,024,868	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	13,148	37,334	0	3,802	54,284	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
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)	353,079,152	11,245,111	16,257,325	39,797,797	353,079,152	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-0213

Period:
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	75,465,840				5.00
7.00	00700	OPERATION OF PLANT	3,168,565	14,824,643			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	87,654	83,195	493,300		8.00
9.00	00900	HOUSEKEEPING	1,423,330	206,256	0	6,865,537	9.00
10.00	01000	DIETARY	500,651	819,719	0	387,185	10.00
11.00	01100	CAFETERIA	553,553	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,236,949	103,759	0	49,009	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	455,203	661,447	444	312,427	14.00
15.00	01500	PHARMACY	2,110,650	273,035	0	128,965	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,101,580	38,639	0	18,251	16.00
17.00	01700	SOCIAL SERVICE	9,633	0	0	0	17.00
23.00	02300	PARAMED ED PRGM	139,138	30,233	11,137	14,280	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,001,130	4,761,702	203,582	2,249,138	30.00
31.00	03100	INTENSIVE CARE UNIT	3,099,895	612,525	34,091	289,320	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	1,718,693	727,613	12,578	343,680	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	1,201,513	1,642,432	0	775,785	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,676,528	1,980,660	74,982	935,543	50.00
51.00	05100	RECOVERY ROOM	531,805	156,469	17,775	73,906	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,630,907	0	28,288	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,614,102	884,406	27,537	417,739	54.00
54.01	05401	ULTRASOUND	530,617	108,305	2,581	51,157	54.01
57.00	05700	CT SCAN	818,985	97,157	4,091	45,891	57.00
58.00	05800	MRI	398,868	125,261	6,767	59,166	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	3,441,674	21,610	0	10,207	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	496,404	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	925,774	70,892	0	33,485	65.00
65.01	06501	SLEEP LAB	119,052	0	69	0	65.01
66.00	06600	PHYSICAL THERAPY	593,875	8,983	0	4,243	66.00
67.00	06700	OCCUPATIONAL THERAPY	633,573	0	5,919	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	556,896	52,529	323	24,811	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	71,066	37,521	0	17,722	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,939,588	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,488,278	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,753,311	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	215,303	104,481	0	49,350	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	265,875	0	238	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	90.02
90.03	09003	WOMENS HEALTH	0	0	0	0	90.03
91.00	09100	EMERGENCY	3,616,456	1,150,550	62,898	543,450	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	88,821	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	1,235,189	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	75,451,084	14,759,379	493,300	6,834,710	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	14,756	65,264	0	30,827	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	192.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
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)	75,465,840	14,824,643	493,300	6,865,537	3,549,279	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	2,589,887					11.00
13.00	01300	NURSING ADMINISTRATION	68,657	6,008,689				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	72,471	0	3,176,530			14.00
15.00	01500	PHARMACY	76,285	0	0	10,353,303		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	83,914	0	0	0	5,294,724	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM	7,629	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	703,732	3,292,828	0	0	2,263,707	30.00
31.00	03100	INTENSIVE CARE UNIT	173,549	811,887	0	0	644,984	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	101,078	476,703	0	0	163,695	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	225,042	1,055,564	0	0	226,289	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	228,856	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	24,793	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	200,249	0	0	0	0	54.00
54.01	05401	ULTRASOUND	26,700	0	0	0	0	54.01
57.00	05700	CT SCAN	30,514	0	0	0	0	57.00
58.00	05800	MRI	13,350	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	131,592	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	5,721	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	59,121	0	0	0	0	65.00
65.01	06501	SLEEP LAB	7,629	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	30,514	0	0	0	487,412	66.00
67.00	06700	OCCUPATIONAL THERAPY	34,328	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	34,328	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,721	0	0	0	113,212	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	3,176,530	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,353,303	0	73.00
74.00	07400	RENAL DIALYSIS	9,536	42,068	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	11,443	0	0	0	21,363	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMENS HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	215,506	0	0	0	1,374,062	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	7,629	35,306	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	294,333	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,589,887	6,008,689	3,176,530	10,353,303	5,294,724	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
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4/29/2021 3:44 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
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)	2,589,887	6,008,689	3,176,530	10,353,303	5,294,724	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
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4/29/2021 3:44 pm

Cost Center Description		SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
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	45,070				17.00
23.00	02300	PARAMED ED PRGM	0	714,257			23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	39,148	0	71,776,224	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,401	0	17,840,991	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	10,533,809	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	9,546,586	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	39,135,916	0	50.00
51.00	05100	RECOVERY ROOM	0	0	2,761,077	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	17,433	7,676,183	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	23,117,751	0	54.00
54.01	05401	ULTRASOUND	0	0	2,671,320	0	54.01
57.00	05700	CT SCAN	0	0	4,009,406	0	57.00
58.00	05800	MRI	0	0	2,070,714	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	16,265,835	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	2,328,228	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	4,494,882	0	65.00
65.01	06501	SLEEP LAB	0	0	564,701	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	3,309,692	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	3,004,519	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	17,045	2,734,563	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	506,668	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	40,323,176	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	30,356,457	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	27,913,776	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	1,212,764	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	560	0	1,277,543	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	90.02
90.03	09003	WOMENS HEALTH	0	0	0	0	90.03
91.00	09100	EMERGENCY	2,961	679,779	20,949,378	0	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0	0	458,497	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	6,073,365	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	45,070	714,257	352,914,021	0	118.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
4/29/2021 3:44 pm

Cost Center Description			SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	23.00	24.00	25.00	26.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	165,131	0	165,131	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments		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)	45,070	714,257	353,079,152	0	353,079,152	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/29/2021 3:44 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	41,668	0	41,668	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	2,584,660	9,947,132	12,531,792	5.00
7.00	00700	OPERATION OF PLANT	0	138,358	102,280	240,638	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	47,592	0	47,592	8.00
9.00	00900	HOUSEKEEPING	0	117,988	3,190	121,178	9.00
10.00	01000	DIETARY	0	468,919	4,855	473,774	10.00
11.00	01100	CAFETERIA	0	0	13,117	13,117	11.00
13.00	01300	NURSING ADMINISTRATION	0	59,355	71,632	130,987	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	378,380	166,689	545,069	14.00
15.00	01500	PHARMACY	0	156,190	42,632	198,822	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	22,103	1,650	23,753	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM	0	17,295	15,574	32,869	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	2,723,927	336,478	3,060,405	30.00
31.00	03100	INTENSIVE CARE UNIT	0	350,395	187,945	538,340	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	416,230	17,693	433,923	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	939,552	40,370	979,922	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,133,035	2,863,551	3,996,586	50.00
51.00	05100	RECOVERY ROOM	0	89,508	345	89,853	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	90,675	90,675	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	505,924	1,254,486	1,760,410	54.00
54.01	05401	ULTRASOUND	0	61,956	21,467	83,423	54.01
57.00	05700	CT SCAN	0	55,579	325,618	381,197	57.00
58.00	05800	MRI	0	71,656	24,598	96,254	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	12,362	203,850	216,212	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	12,096	12,096	63.00
65.00	06500	RESPIRATORY THERAPY	0	40,554	53,540	94,094	65.00
65.01	06501	SLEEP LAB	0	0	1,625	1,625	65.01
66.00	06600	PHYSICAL THERAPY	0	5,139	2,018	7,157	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	28,846	28,846	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	30,049	179,303	209,352	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	21,464	19,434	40,898	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	59,768	7,932	67,700	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	2,162	2,162	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	90.02
90.03	09003	WOMENS HEALTH	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	658,171	213,184	871,355	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0	0	271	271	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	1,087	1,087	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/29/2021 3:44 pm

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
118.00							
	SUBTOTALS (SUM OF LINES 1 through 117)						
		0	11,207,777	16,257,325	27,465,102	41,664	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	37,334	0	37,334	4190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0192.00
200.00		Cross Foot Adjustments			0	0	200.00
201.00		Negative Cost Centers		0	0	0	0201.00
202.00		TOTAL (sum lines 118 through 201)	0	11,245,111	16,257,325	27,502,436	41,668202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,537,804				5.00
7.00	00700	OPERATION OF PLANT	526,423	768,111			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	14,563	4,311	66,487		8.00
9.00	00900	HOUSEKEEPING	236,471	10,687	0	369,188	9.00
10.00	01000	DIETARY	83,178	42,472	0	20,821	620,426 10.00
11.00	01100	CAFETERIA	91,967	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	205,506	5,376	0	2,635	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	75,627	34,272	60	16,800	0 14.00
15.00	01500	PHARMACY	350,662	14,147	0	6,935	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	183,016	2,002	0	981	0 16.00
17.00	01700	SOCIAL SERVICE	1,600	0	0	0	0 17.00
23.00	02300	PARAMED ED PRGM	23,116	1,566	1,501	768	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,993,814	246,717	27,439	120,944	369,382 30.00
31.00	03100	INTENSIVE CARE UNIT	515,015	31,737	4,595	15,558	134,402 31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0 33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0 40.00
41.00	04100	SUBPROVIDER - IRF	285,543	37,700	1,695	18,481	116,642 41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0 42.00
43.00	04300	NURSERY	199,619	85,100	0	41,717	0 43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0 45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,275,374	102,624	10,106	50,308	0 50.00
51.00	05100	RECOVERY ROOM	88,354	8,107	2,396	3,974	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	270,958	0	3,813	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	766,584	45,824	3,711	22,464	0 54.00
54.01	05401	ULTRASOUND	88,156	5,612	348	2,751	0 54.01
57.00	05700	CT SCAN	136,066	5,034	551	2,468	0 57.00
58.00	05800	MRI	66,268	6,490	912	3,182	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00	06000	LABORATORY	571,798	1,120	0	549	0 60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0 60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	82,472	0	0	0	0 63.00
65.00	06500	RESPIRATORY THERAPY	153,808	3,673	0	1,801	0 65.00
65.01	06501	SLEEP LAB	19,779	0	9	0	0 65.01
66.00	06600	PHYSICAL THERAPY	98,666	465	0	228	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	105,261	0	798	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	92,522	2,722	44	1,334	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	11,807	1,944	0	953	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,319,078	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,077,959	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	623,573	0	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	35,770	5,413	0	2,654	0 74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
90.00	09000	CLINIC	44,172	0	32	0	0 90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0 90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0 90.02
90.03	09003	WOMENS HEALTH	0	0	0	0	0 90.03
91.00	09100	EMERGENCY	600,836	59,614	8,477	29,224	0 91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0 91.01
91.02	09102	DIABETES CENTER	14,757	0	0	0	0 91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0 94.00
99.00	09900	CMHC	0	0	0	0	0 99.00
99.10	09910	CORF	0	0	0	0	0 99.10
101.00	10100	HOME HEALTH AGENCY	205,214	0	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0 109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0 111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,535,352	764,729	66,487	367,530	620,426 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	2,452	3,382	0	1,658	0 190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0 192.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/29/2021 3:44 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
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)	12,537,804	768,111	66,487	369,188	620,426	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/29/2021 3:44 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	105,574					11.00
13.00	01300	NURSING ADMINISTRATION	2,799	348,334				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,954	0	675,004			14.00
15.00	01500	PHARMACY	3,110	0	0	574,890		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,421	0	0	0	214,033	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM	311	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	28,687	190,891	0	0	91,508	30.00
31.00	03100	INTENSIVE CARE UNIT	7,075	47,066	0	0	26,073	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	4,120	27,635	0	0	6,617	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	9,174	61,193	0	0	9,147	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,329	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	1,011	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,163	0	0	0	0	54.00
54.01	05401	ULTRASOUND	1,088	0	0	0	0	54.01
57.00	05700	CT SCAN	1,244	0	0	0	0	57.00
58.00	05800	MRI	544	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	5,364	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	233	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	2,410	0	0	0	0	65.00
65.01	06501	SLEEP LAB	311	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	1,244	0	0	0	19,703	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,399	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,399	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	233	0	0	0	4,576	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	675,004	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	574,890	0	73.00
74.00	07400	RENAL DIALYSIS	389	2,439	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	466	0	0	0	864	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMENS HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	8,785	0	0	0	55,545	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	311	2,047	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	17,063	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	105,574	348,334	675,004	574,890	214,033	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/29/2021 3:44 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
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)	105,574	348,334	675,004	574,890	214,033	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/29/2021 3:44 pm

Cost Center Description		SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
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	1,608				17.00
23.00	02300	PARAMED ED PRGM	0	60,218			23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,396	6,140,510	0	6,140,510	30.00
31.00	03100	INTENSIVE CARE UNIT	86	1,322,313	0	1,322,313	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	933,619	0	933,619	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	1,386,526	0	1,386,526	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	5,447,595	0	5,447,595	50.00
51.00	05100	RECOVERY ROOM	0	194,119	0	194,119	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	366,760	0	366,760	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,609,686	0	2,609,686	54.00
54.01	05401	ULTRASOUND	0	181,756	0	181,756	54.01
57.00	05700	CT SCAN	0	526,948	0	526,948	57.00
58.00	05800	MRI	0	173,866	0	173,866	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	796,415	0	796,415	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	94,878	0	94,878	63.00
65.00	06500	RESPIRATORY THERAPY	0	256,453	0	256,453	65.00
65.01	06501	SLEEP LAB	0	21,789	0	21,789	65.01
66.00	06600	PHYSICAL THERAPY	0	127,898	0	127,898	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	136,754	0	136,754	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	307,805	0	307,805	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	60,457	0	60,457	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,994,082	0	1,994,082	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,077,959	0	1,077,959	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,198,463	0	1,198,463	73.00
74.00	07400	RENAL DIALYSIS	0	114,514	0	114,514	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	20	47,911	0	47,911	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	90.02
90.03	09003	WOMENS HEALTH	0	0	0	0	90.03
91.00	09100	EMERGENCY	106	1,636,563	0	1,636,563	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0	17,461	0	17,461	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	224,288	0	224,288	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,608	0	27,397,388	0	27,397,388

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/29/2021 3:44 pm

Cost Center Description			SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	23.00	24.00	25.00	26.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0		44,830	0	44,830	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0		0	0	0	192.00
200.00		Cross Foot Adjustments		60,218	60,218	0	60,218	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,608	60,218	27,502,436	0	27,502,436	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/29/2021 3:44 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	544,870				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		15,984,769			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,019	0	137,627,291		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	125,237	9,780,370	19,840,563	-75,465,840	5.00
7.00	00700	OPERATION OF PLANT	6,704	100,565	3,464,459	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,306	0	70,799	0	8.00
9.00	00900	HOUSEKEEPING	5,717	3,137	2,811,457	0	9.00
10.00	01000	DIETARY	22,721	4,774	598,857	0	10.00
11.00	01100	CAFETERIA	0	12,897	1,617,948	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,876	70,431	3,402,369	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	18,334	163,894	733,462	0	14.00
15.00	01500	PHARMACY	7,568	41,917	4,006,078	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,071	1,622	2,837,555	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	27,488	0	17.00
23.00	02300	PARAMED ED PRGM	838	15,313	286,648	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	131,985	330,837	30,880,730	0	30.00
31.00	03100	INTENSIVE CARE UNIT	16,978	184,794	7,809,101	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	20,168	17,396	4,169,853	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	45,525	39,693	2,159,494	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	54,900	2,815,543	10,786,677	0	50.00
51.00	05100	RECOVERY ROOM	4,337	339	1,399,413	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	89,155	4,337,194	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,514	1,233,454	8,348,538	0	54.00
54.01	05401	ULTRASOUND	3,002	21,107	1,247,179	0	54.01
57.00	05700	CT SCAN	2,693	320,159	1,281,024	0	57.00
58.00	05800	MRI	3,472	24,186	711,630	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	599	200,432	4,528,812	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	11,893	255,348	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,965	52,642	2,201,840	0	65.00
65.01	06501	SLEEP LAB	0	1,598	213,763	0	65.01
66.00	06600	PHYSICAL THERAPY	249	1,984	1,436,901	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	28,362	1,484,924	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,456	176,297	1,426,522	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,040	19,108	152,534	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,896	7,799	493,180	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	2,126	644,036	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	90.02
90.03	09003	WOMENS HEALTH	0	0	0	0	90.03
91.00	09100	EMERGENCY	31,891	209,610	8,649,988	0	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0	266	247,449	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	1,069	3,050,330	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/29/2021 3:44 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	543,061	15,984,769	137,614,143	-75,465,840	277,559,028	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	1,809	0	13,148	0	54,284	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
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)	11,245,111	16,257,325	39,797,797		75,465,840	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	20.638154	1.017051	0.289171		0.271838	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			41,668		12,537,804	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000303		0.045163	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:14-0213

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/29/2021 3:44 pm

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER HOUSED)	
			7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	410,910					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,306	2,471,622				8.00
9.00	00900	HOUSEKEEPING	5,717	0	402,887			9.00
10.00	01000	DIETARY	22,721	0	22,721	260,580		10.00
11.00	01100	CAFETERIA	0	0	0	0	1,358	11.00
13.00	01300	NURSING ADMINISTRATION	2,876	0	2,876	0	36	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	18,334	2,225	18,334	0	38	14.00
15.00	01500	PHARMACY	7,568	0	7,568	0	40	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,071	0	1,071	0	44	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM	838	55,802	838	0	4	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	131,985	1,020,025	131,985	155,141	369	30.00
31.00	03100	INTENSIVE CARE UNIT	16,978	170,807	16,978	56,449	91	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	20,168	63,022	20,168	48,990	53	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	45,525	0	45,525	0	118	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	54,900	375,687	54,900	0	120	50.00
51.00	05100	RECOVERY ROOM	4,337	89,058	4,337	0	13	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	141,734	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,514	137,969	24,514	0	105	54.00
54.01	05401	ULTRASOUND	3,002	12,933	3,002	0	14	54.01
57.00	05700	CT SCAN	2,693	20,498	2,693	0	16	57.00
58.00	05800	MRI	3,472	33,906	3,472	0	7	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	599	0	599	0	69	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	0	3	63.00
65.00	06500	RESPIRATORY THERAPY	1,965	0	1,965	0	31	65.00
65.01	06501	SLEEP LAB	0	348	0	0	4	65.01
66.00	06600	PHYSICAL THERAPY	249	0	249	0	16	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	29,655	0	0	18	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,456	1,619	1,456	0	18	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,040	0	1,040	0	3	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,896	0	2,896	0	5	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	1,193	0	0	6	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMENS HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	31,891	315,141	31,891	0	113	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0	0	0	0	4	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	409,101	2,471,622	401,078	260,580	1,358	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/29/2021 3:44 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER HOUSED)	
		7.00	8.00	9.00	10.00	11.00	
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	1,809	0	1,809	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	192.00
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)	14,824,643	493,300	6,865,537	3,549,279	2,589,887
203.00		Unit cost multiplier (Wkst. B, Part I)	36.077591	0.199586	17.040850	13.620688	1,907.133284
204.00		Cost to be allocated (per Wkst. B, Part II)	768,111	66,487	369,188	620,426	105,574
205.00		Unit cost multiplier (Wkst. B, Part II)	1.869293	0.026900	0.916356	2.380943	77.742268
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:14-0213

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/29/2021 3:44 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	1,402,196				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	38,467,466			14.00
15.00	01500	PHARMACY	0	0	13,918,249		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	38,911	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM	0	0	0	2,816	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	768,419	0	0	16,636	30.00
31.00	03100	INTENSIVE CARE UNIT	189,463	0	0	4,740	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	111,244	0	0	1,203	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	246,328	0	0	1,663	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	3,582	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	832	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	38,467,466	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	13,918,249	0	73.00
74.00	07400	RENAL DIALYSIS	9,817	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	157	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	90.02
90.03	09003	WOMENS HEALTH	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	10,098	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	8,239	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	68,686	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,402,196	38,467,466	13,918,249	38,911	2,816

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/29/2021 3:44 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
		13.00	14.00	15.00	16.00	17.00	
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	192.00
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)	6,008,689	3,176,530	10,353,303	5,294,724	45,070
203.00		Unit cost multiplier (Wkst. B, Part I)	4.285199	0.082577	0.743865	136.072679	16.004972
204.00		Cost to be allocated (per Wkst. B, Part II)	348,334	675,004	574,890	214,033	1,608
205.00		Unit cost multiplier (Wkst. B, Part II)	0.248420	0.017547	0.041305	5.500578	0.571023
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:14-0213

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/29/2021 3:44 pm

Cost Center Description		PARAMED ED PRGM	
		(ASSIGNED TIME)	
		23.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
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
23.00	02300	PARAMED ED PRGM	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	33.00
40.00	04000	SUBPROVIDER - IPF	40.00
41.00	04100	SUBPROVIDER - IRF	41.00
42.00	04200	SUBPROVIDER	42.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
45.00	04500	NURSING FACILITY	45.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	ULTRASOUND	54.01
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
60.01	06001	BLOOD LABORATORY	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	63.00
65.00	06500	RESPIRATORY THERAPY	65.00
65.01	06501	SLEEP LAB	65.01
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	89.00
90.00	09000	CLINIC	90.00
90.01	09001	HOMER GLEN LAB	90.01
90.02	09002	HOMER GLEN FEC	90.02
90.03	09003	WOMENS HEALTH	90.03
91.00	09100	EMERGENCY	91.00
91.01	09101	OP MENTAL HEALTH	91.01
91.02	09102	DIABETES CENTER	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
OTHER REIMBURSABLE COST CENTERS			
94.00	09400	HOME PROGRAM DIALYSIS	94.00
99.00	09900	CMHC	99.00
99.10	09910	CORF	99.10
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
109.00	10900	PANCREAS ACQUISITION	109.00
110.00	11000	INTESTINAL ACQUISITION	110.00
111.00	11100	ISLET ACQUISITION	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	190.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/29/2021 3:44 pm

Cost Center Description		PARAMED ED PRGM	
		(ASSIGNED TIME)	
		23.00	
192.00	19200	PHYSICIANS PRIVATE OFFICES	0
200.00		Cross Foot Adjustments	
201.00		Negative Cost Centers	
202.00		Cost to be allocated (per Wkst. B, Part I)	714,257
203.00		Unit cost multiplier (Wkst. B, Part I)	96.848407
204.00		Cost to be allocated (per Wkst. B, Part II)	60,218
205.00		Unit cost multiplier (Wkst. B, Part II)	8.165153
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	0
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0.000000

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/29/2021 3:44 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	71,776,224		71,776,224	99,165	71,875,389
31.00	03100	INTENSIVE CARE UNIT	17,840,991		17,840,991	23,920	17,864,911
33.00	03300	BURN INTENSIVE CARE UNIT	0		0	0	0
40.00	04000	SUBPROVIDER - IPF	0		0	0	0
41.00	04100	SUBPROVIDER - IRF	10,533,809		10,533,809	0	10,533,809
42.00	04200	SUBPROVIDER	0		0	0	0
43.00	04300	NURSERY	9,546,586		9,546,586	0	9,546,586
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0
45.00	04500	NURSING FACILITY	0		0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	39,135,916		39,135,916	17,452	39,153,368
51.00	05100	RECOVERY ROOM	2,761,077		2,761,077	0	2,761,077
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,676,183		7,676,183	0	7,676,183
53.00	05300	ANESTHESIOLOGY	0		0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,117,751		23,117,751	81,879	23,199,630
54.01	05401	ULTRASOUND	2,671,320		2,671,320	0	2,671,320
57.00	05700	CT SCAN	4,009,406		4,009,406	0	4,009,406
58.00	05800	MRI	2,070,714		2,070,714	0	2,070,714
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0
60.00	06000	LABORATORY	16,265,835		16,265,835	78,438	16,344,273
60.01	06001	BLOOD LABORATORY	0		0	0	0
63.00	06300	BLOOD STORING PROCESSING & TRANS.	2,328,228		2,328,228	0	2,328,228
65.00	06500	RESPIRATORY THERAPY	4,494,882	0	4,494,882	2,127	4,497,009
65.01	06501	SLEEP LAB	564,701	0	564,701	0	564,701
66.00	06600	PHYSICAL THERAPY	3,309,692	0	3,309,692	0	3,309,692
67.00	06700	OCCUPATIONAL THERAPY	3,004,519	0	3,004,519	0	3,004,519
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	2,734,563		2,734,563	15,976	2,750,539
70.00	07000	ELECTROENCEPHALOGRAPHY	506,668		506,668	36,958	543,626
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	40,323,176		40,323,176	0	40,323,176
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,356,457		30,356,457	0	30,356,457
73.00	07300	DRUGS CHARGED TO PATIENTS	27,913,776		27,913,776	0	27,913,776
74.00	07400	RENAL DIALYSIS	1,212,764		1,212,764	4,466	1,217,230
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0
90.00	09000	CLINIC	1,277,543		1,277,543	767	1,278,310
90.01	09001	HOMER GLEN LAB	0		0	0	0
90.02	09002	HOMER GLEN FEC	0		0	0	0
90.03	09003	WOMENS HEALTH	0		0	0	0
91.00	09100	EMERGENCY	20,949,378		20,949,378	48,741	20,998,119
91.01	09101	OP MENTAL HEALTH	0		0	0	0
91.02	09102	DIABETES CENTER	458,497		458,497	0	458,497
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	9,532,774		9,532,774	0	9,532,774
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0		0	0	0
99.00	09900	CMHC	0		0	0	0
99.10	09910	CORF	0		0	0	0
101.00	10100	HOME HEALTH AGENCY	6,073,365		6,073,365	0	6,073,365
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0		0	0	0
110.00	11000	INTESTINAL ACQUISITION	0		0	0	0
111.00	11100	ISLET ACQUISITION	0		0	0	0
200.00		Subtotal (see instructions)	362,446,795	0	362,446,795	409,889	362,856,684
201.00		Less Observation Beds	9,532,774		9,532,774	0	9,532,774
202.00		Total (see instructions)	352,914,021	0	352,914,021	409,889	353,323,910

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/29/2021 3:44 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	9.00	10.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	72,627,216		72,627,216			30.00		
31.00	03100	INTENSIVE CARE UNIT	24,376,986		24,376,986			31.00		
33.00	03300	BURN INTENSIVE CARE UNIT	0		0			33.00		
40.00	04000	SUBPROVIDER - IPF	0		0			40.00		
41.00	04100	SUBPROVIDER - IRF	21,155,838		21,155,838			41.00		
42.00	04200	SUBPROVIDER	0		0			42.00		
43.00	04300	NURSERY	10,137,507		10,137,507			43.00		
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00		
45.00	04500	NURSING FACILITY	0		0			45.00		
ANCILLARY SERVICE COST CENTERS										
50.00	05000	OPERATING ROOM	50,588,525	77,729,827	128,318,352	0.304991	0.000000	50.00		
51.00	05100	RECOVERY ROOM	16,077,535	14,070,553	30,148,088	0.091584	0.000000	51.00		
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,134,361	1,037,069	10,171,430	0.754681	0.000000	52.00		
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00		
54.00	05400	RADIOLOGY-DIAGNOSTIC	47,420,090	119,692,882	167,112,972	0.138336	0.000000	54.00		
54.01	05401	ULTRASOUND	9,170,874	20,493,805	29,664,679	0.090051	0.000000	54.01		
57.00	05700	CT SCAN	31,173,489	69,446,925	100,620,414	0.039847	0.000000	57.00		
58.00	05800	MRI	8,695,149	19,445,092	28,140,241	0.073586	0.000000	58.00		
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00		
60.00	06000	LABORATORY	60,005,981	99,068,134	159,074,115	0.102253	0.000000	60.00		
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01		
63.00	06300	BLOOD STORING PROCESSING & TRANS.	8,126,829	3,086,539	11,213,368	0.207630	0.000000	63.00		
65.00	06500	RESPIRATORY THERAPY	12,702,384	2,130,516	14,832,900	0.303035	0.000000	65.00		
65.01	06501	SLEEP LAB	0	2,971,978	2,971,978	0.190008	0.000000	65.01		
66.00	06600	PHYSICAL THERAPY	12,760,825	1,032,386	13,793,211	0.239951	0.000000	66.00		
67.00	06700	OCCUPATIONAL THERAPY	2,915	10,189,585	10,192,500	0.294777	0.000000	67.00		
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00		
69.00	06900	ELECTROCARDIOLOGY	14,039,394	9,951,369	23,990,763	0.113984	0.000000	69.00		
70.00	07000	ELECTROENCEPHALOGRAPHY	966,301	2,376,204	3,342,505	0.151583	0.000000	70.00		
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	41,483,405	37,762,518	79,245,923	0.508836	0.000000	71.00		
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	33,101,507	16,410,221	49,511,728	0.613116	0.000000	72.00		
73.00	07300	DRUGS CHARGED TO PATIENTS	55,016,146	26,173,561	81,189,707	0.343809	0.000000	73.00		
74.00	07400	RENAL DIALYSIS	4,566,221	265,882	4,832,103	0.250981	0.000000	74.00		
OUTPATIENT SERVICE COST CENTERS										
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00		
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00		
90.00	09000	CLINIC	187	1,775,226	1,775,413	0.719575	0.000000	90.00		
90.01	09001	HOMER GLEN LAB	0	0	0	0.000000	0.000000	90.01		
90.02	09002	HOMER GLEN FEC	0	0	0	0.000000	0.000000	90.02		
90.03	09003	WOMENS HEALTH	0	0	0	0.000000	0.000000	90.03		
91.00	09100	EMERGENCY	39,276,532	93,775,693	133,052,225	0.157452	0.000000	91.00		
91.01	09101	OP MENTAL HEALTH	0	0	0	0.000000	0.000000	91.01		
91.02	09102	DIABETES CENTER	130,395	414,056	544,451	0.842127	0.000000	91.02		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,816,911	10,212,740	12,029,651	0.792440	0.000000	92.00		
OTHER REIMBURSABLE COST CENTERS										
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	0.000000	94.00		
99.00	09900	CMHC	0	0	0			99.00		
99.10	09910	CORF	0	0	0			99.10		
101.00	10100	HOME HEALTH AGENCY	0	5,768,567	5,768,567			101.00		
SPECIAL PURPOSE COST CENTERS										
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00		
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00		
111.00	11100	ISLET ACQUISITION	0	0	0			111.00		
200.00		Subtotal (see instructions)	584,553,503	645,281,328	1,229,834,831			200.00		
201.00		Less Observation Beds						201.00		
202.00		Total (see instructions)	584,553,503	645,281,328	1,229,834,831			202.00		

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/29/2021 3:44 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
31.00	03100	INTENSIVE CARE UNIT			31.00
33.00	03300	BURN INTENSIVE CARE UNIT			33.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.305127		50.00
51.00	05100	RECOVERY ROOM	0.091584		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.754681		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.138826		54.00
54.01	05401	ULTRASOUND	0.090051		54.01
57.00	05700	CT SCAN	0.039847		57.00
58.00	05800	MRI	0.073586		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.102746		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.207630		63.00
65.00	06500	RESPIRATORY THERAPY	0.303178		65.00
65.01	06501	SLEEP LAB	0.190008		65.01
66.00	06600	PHYSICAL THERAPY	0.239951		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.294777		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.114650		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.162640		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.508836		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.613116		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.343809		73.00
74.00	07400	RENAL DIALYSIS	0.251905		74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000	CLINIC	0.720007		90.00
90.01	09001	HOMER GLEN LAB	0.000000		90.01
90.02	09002	HOMER GLEN FEC	0.000000		90.02
90.03	09003	WOMENS HEALTH	0.000000		90.03
91.00	09100	EMERGENCY	0.157819		91.00
91.01	09101	OP MENTAL HEALTH	0.000000		91.01
91.02	09102	DIABETES CENTER	0.842127		91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.792440		92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		94.00
99.00	09900	CMHC			99.00
99.10	09910	CORF			99.10
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
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:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/29/2021 3:44 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	71,776,224		71,776,224	99,165	71,875,389	30.00	
31.00	03100	INTENSIVE CARE UNIT	17,840,991		17,840,991	23,920	17,864,911	31.00	
33.00	03300	BURN INTENSIVE CARE UNIT	0		0	0	0	33.00	
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	10,533,809		10,533,809	0	10,533,809	41.00	
42.00	04200	SUBPROVIDER	0		0	0	0	42.00	
43.00	04300	NURSERY	9,546,586		9,546,586	0	9,546,586	43.00	
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00	
45.00	04500	NURSING FACILITY	0		0	0	0	45.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	39,135,916		39,135,916	17,452	39,153,368	50.00	
51.00	05100	RECOVERY ROOM	2,761,077		2,761,077	0	2,761,077	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,676,183		7,676,183	0	7,676,183	52.00	
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,117,751		23,117,751	81,879	23,199,630	54.00	
54.01	05401	ULTRASOUND	2,671,320		2,671,320	0	2,671,320	54.01	
57.00	05700	CT SCAN	4,009,406		4,009,406	0	4,009,406	57.00	
58.00	05800	MRI	2,070,714		2,070,714	0	2,070,714	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00	
60.00	06000	LABORATORY	16,265,835		16,265,835	78,438	16,344,273	60.00	
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01	
63.00	06300	BLOOD STORING PROCESSING & TRANS.	2,328,228		2,328,228	0	2,328,228	63.00	
65.00	06500	RESPIRATORY THERAPY	4,494,882	0	4,494,882	2,127	4,497,009	65.00	
65.01	06501	SLEEP LAB	564,701	0	564,701	0	564,701	65.01	
66.00	06600	PHYSICAL THERAPY	3,309,692	0	3,309,692	0	3,309,692	66.00	
67.00	06700	OCCUPATIONAL THERAPY	3,004,519	0	3,004,519	0	3,004,519	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	2,734,563		2,734,563	15,976	2,750,539	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	506,668		506,668	36,958	543,626	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	40,323,176		40,323,176	0	40,323,176	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,356,457		30,356,457	0	30,356,457	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	27,913,776		27,913,776	0	27,913,776	73.00	
74.00	07400	RENAL DIALYSIS	1,212,764		1,212,764	4,466	1,217,230	74.00	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00	
90.00	09000	CLINIC	1,277,543		1,277,543	767	1,278,310	90.00	
90.01	09001	HOMER GLEN LAB	0		0	0	0	90.01	
90.02	09002	HOMER GLEN FEC	0		0	0	0	90.02	
90.03	09003	WOMENS HEALTH	0		0	0	0	90.03	
91.00	09100	EMERGENCY	20,949,378		20,949,378	48,741	20,998,119	91.00	
91.01	09101	OP MENTAL HEALTH	0		0	0	0	91.01	
91.02	09102	DIABETES CENTER	458,497		458,497	0	458,497	91.02	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	9,532,774		9,532,774	0	9,532,774	92.00	
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS	0		0	0	0	94.00	
99.00	09900	CMHC	0		0	0	0	99.00	
99.10	09910	CORF	0		0	0	0	99.10	
101.00	10100	HOME HEALTH AGENCY	6,073,365		6,073,365	0	6,073,365	101.00	
SPECIAL PURPOSE COST CENTERS									
109.00	10900	PANCREAS ACQUISITION	0		0	0	0	109.00	
110.00	11000	INTESTINAL ACQUISITION	0		0	0	0	110.00	
111.00	11100	ISLET ACQUISITION	0		0	0	0	111.00	
200.00		Subtotal (see instructions)	362,446,795	0	362,446,795	409,889	362,856,684	200.00	
201.00		Less Observation Beds	9,532,774		9,532,774	0	9,532,774	201.00	
202.00		Total (see instructions)	352,914,021	0	352,914,021	409,889	353,323,910	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/29/2021 3:44 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	72,627,216		72,627,216			30.00		
31.00	03100	INTENSIVE CARE UNIT	24,376,986		24,376,986			31.00		
33.00	03300	BURN INTENSIVE CARE UNIT	0		0			33.00		
40.00	04000	SUBPROVIDER - IPF	0		0			40.00		
41.00	04100	SUBPROVIDER - IRF	21,155,838		21,155,838			41.00		
42.00	04200	SUBPROVIDER	0		0			42.00		
43.00	04300	NURSERY	10,137,507		10,137,507			43.00		
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00		
45.00	04500	NURSING FACILITY	0		0			45.00		
ANCILLARY SERVICE COST CENTERS										
50.00	05000	OPERATING ROOM	50,588,525	77,729,827	128,318,352	0.304991	0.000000	50.00		
51.00	05100	RECOVERY ROOM	16,077,535	14,070,553	30,148,088	0.091584	0.000000	51.00		
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,134,361	1,037,069	10,171,430	0.754681	0.000000	52.00		
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00		
54.00	05400	RADIOLOGY-DIAGNOSTIC	47,420,090	119,692,882	167,112,972	0.138336	0.000000	54.00		
54.01	05401	ULTRASOUND	9,170,874	20,493,805	29,664,679	0.090051	0.000000	54.01		
57.00	05700	CT SCAN	31,173,489	69,446,925	100,620,414	0.039847	0.000000	57.00		
58.00	05800	MRI	8,695,149	19,445,092	28,140,241	0.073586	0.000000	58.00		
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00		
60.00	06000	LABORATORY	60,005,981	99,068,134	159,074,115	0.102253	0.000000	60.00		
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01		
63.00	06300	BLOOD STORING PROCESSING & TRANS.	8,126,829	3,086,539	11,213,368	0.207630	0.000000	63.00		
65.00	06500	RESPIRATORY THERAPY	12,702,384	2,130,516	14,832,900	0.303035	0.000000	65.00		
65.01	06501	SLEEP LAB	0	2,971,978	2,971,978	0.190008	0.000000	65.01		
66.00	06600	PHYSICAL THERAPY	12,760,825	1,032,386	13,793,211	0.239951	0.000000	66.00		
67.00	06700	OCCUPATIONAL THERAPY	2,915	10,189,585	10,192,500	0.294777	0.000000	67.00		
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00		
69.00	06900	ELECTROCARDIOLOGY	14,039,394	9,951,369	23,990,763	0.113984	0.000000	69.00		
70.00	07000	ELECTROENCEPHALOGRAPHY	966,301	2,376,204	3,342,505	0.151583	0.000000	70.00		
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	41,483,405	37,762,518	79,245,923	0.508836	0.000000	71.00		
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	33,101,507	16,410,221	49,511,728	0.613116	0.000000	72.00		
73.00	07300	DRUGS CHARGED TO PATIENTS	55,016,146	26,173,561	81,189,707	0.343809	0.000000	73.00		
74.00	07400	RENAL DIALYSIS	4,566,221	265,882	4,832,103	0.250981	0.000000	74.00		
OUTPATIENT SERVICE COST CENTERS										
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00		
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00		
90.00	09000	CLINIC	187	1,775,226	1,775,413	0.719575	0.000000	90.00		
90.01	09001	HOMER GLEN LAB	0	0	0	0.000000	0.000000	90.01		
90.02	09002	HOMER GLEN FEC	0	0	0	0.000000	0.000000	90.02		
90.03	09003	WOMENS HEALTH	0	0	0	0.000000	0.000000	90.03		
91.00	09100	EMERGENCY	39,276,532	93,775,693	133,052,225	0.157452	0.000000	91.00		
91.01	09101	OP MENTAL HEALTH	0	0	0	0.000000	0.000000	91.01		
91.02	09102	DIABETES CENTER	130,395	414,056	544,451	0.842127	0.000000	91.02		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,816,911	10,212,740	12,029,651	0.792440	0.000000	92.00		
OTHER REIMBURSABLE COST CENTERS										
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	0.000000	94.00		
99.00	09900	CMHC	0	0	0			99.00		
99.10	09910	CORF	0	0	0			99.10		
101.00	10100	HOME HEALTH AGENCY	0	5,768,567	5,768,567			101.00		
SPECIAL PURPOSE COST CENTERS										
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00		
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00		
111.00	11100	ISLET ACQUISITION	0	0	0			111.00		
200.00		Subtotal (see instructions)	584,553,503	645,281,328	1,229,834,831			200.00		
201.00		Less Observation Beds						201.00		
202.00		Total (see instructions)	584,553,503	645,281,328	1,229,834,831			202.00		

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/29/2021 3:44 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
31.00	03100	INTENSIVE CARE UNIT			31.00
33.00	03300	BURN INTENSIVE CARE UNIT			33.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.305127		50.00
51.00	05100	RECOVERY ROOM	0.091584		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.754681		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.138826		54.00
54.01	05401	ULTRASOUND	0.090051		54.01
57.00	05700	CT SCAN	0.039847		57.00
58.00	05800	MRI	0.073586		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.102746		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.207630		63.00
65.00	06500	RESPIRATORY THERAPY	0.303178		65.00
65.01	06501	SLEEP LAB	0.190008		65.01
66.00	06600	PHYSICAL THERAPY	0.239951		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.294777		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.114650		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.162640		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.508836		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.613116		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.343809		73.00
74.00	07400	RENAL DIALYSIS	0.251905		74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.720007		90.00
90.01	09001	HOMER GLEN LAB	0.000000		90.01
90.02	09002	HOMER GLEN FEC	0.000000		90.02
90.03	09003	WOMENS HEALTH	0.000000		90.03
91.00	09100	EMERGENCY	0.157819		91.00
91.01	09101	OP MENTAL HEALTH	0.000000		91.01
91.02	09102	DIABETES CENTER	0.842127		91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.792440		92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		94.00
99.00	09900	CMHC			99.00
99.10	09910	CORF			99.10
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
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:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part II
Date/Time Prepared:
4/29/2021 3:44 pm

Cost Center Description		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	39,135,916	5,447,595	33,688,321	0	0	50.00
51.00	05100 RECOVERY ROOM	2,761,077	194,119	2,566,958	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	7,676,183	366,760	7,309,423	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	23,117,751	2,609,686	20,508,065	0	0	54.00
54.01	05401 ULTRASOUND	2,671,320	181,756	2,489,564	0	0	54.01
57.00	05700 CT SCAN	4,009,406	526,948	3,482,458	0	0	57.00
58.00	05800 MRI	2,070,714	173,866	1,896,848	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	16,265,835	796,415	15,469,420	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300 BLOOD STORING PROCESSING & TRANS.	2,328,228	94,878	2,233,350	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	4,494,882	256,453	4,238,429	0	0	65.00
65.01	06501 SLEEP LAB	564,701	21,789	542,912	0	0	65.01
66.00	06600 PHYSICAL THERAPY	3,309,692	127,898	3,181,794	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	3,004,519	136,754	2,867,765	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	2,734,563	307,805	2,426,758	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	506,668	60,457	446,211	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	40,323,176	1,994,082	38,329,094	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	30,356,457	1,077,959	29,278,498	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	27,913,776	1,198,463	26,715,313	0	0	73.00
74.00	07400 RENAL DIALYSIS	1,212,764	114,514	1,098,250	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	1,277,543	47,911	1,229,632	0	0	90.00
90.01	09001 HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002 HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003 WOMENS HEALTH	0	0	0	0	0	90.03
91.00	09100 EMERGENCY	20,949,378	1,636,563	19,312,815	0	0	91.00
91.01	09101 OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102 DIABETES CENTER	458,497	17,461	441,036	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	9,532,774	814,413	8,718,361	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900 CMHC	0	0	0	0	0	99.00
99.10	09910 CORF	0	0	0	0	0	99.10
101.00	10100 HOME HEALTH AGENCY	6,073,365	224,288	5,849,077	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	0	0	0	111.00
200.00	Subtotal (sum of lines 50 thru 199)	252,749,185	18,428,833	234,320,352	0	0	200.00
201.00	Less Observation Beds	9,532,774	814,413	8,718,361	0	0	201.00
202.00	Total (line 200 minus line 201)	243,216,411	17,614,420	225,601,991	0	0	202.00

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

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part II
Date/Time Prepared:
4/29/2021 3:44 pm

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)	Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	39,135,916	128,318,352	0.304991		50.00
51.00	05100 RECOVERY ROOM	2,761,077	30,148,088	0.091584		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	7,676,183	10,171,430	0.754681		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	23,117,751	167,112,972	0.138336		54.00
54.01	05401 ULTRASOUND	2,671,320	29,664,679	0.090051		54.01
57.00	05700 CT SCAN	4,009,406	100,620,414	0.039847		57.00
58.00	05800 MRI	2,070,714	28,140,241	0.073586		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000		59.00
60.00	06000 LABORATORY	16,265,835	159,074,115	0.102253		60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000		60.01
63.00	06300 BLOOD STORING PROCESSING & TRANS.	2,328,228	11,213,368	0.207630		63.00
65.00	06500 RESPIRATORY THERAPY	4,494,882	14,832,900	0.303035		65.00
65.01	06501 SLEEP LAB	564,701	2,971,978	0.190008		65.01
66.00	06600 PHYSICAL THERAPY	3,309,692	13,793,211	0.239951		66.00
67.00	06700 OCCUPATIONAL THERAPY	3,004,519	10,192,500	0.294777		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	2,734,563	23,990,763	0.113984		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	506,668	3,342,505	0.151583		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	40,323,176	79,245,923	0.508836		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	30,356,457	49,511,728	0.613116		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	27,913,776	81,189,707	0.343809		73.00
74.00	07400 RENAL DIALYSIS	1,212,764	4,832,103	0.250981		74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000		89.00
90.00	09000 CLINIC	1,277,543	1,775,413	0.719575		90.00
90.01	09001 HOMER GLEN LAB	0	0	0.000000		90.01
90.02	09002 HOMER GLEN FEC	0	0	0.000000		90.02
90.03	09003 WOMENS HEALTH	0	0	0.000000		90.03
91.00	09100 EMERGENCY	20,949,378	133,052,225	0.157452		91.00
91.01	09101 OP MENTAL HEALTH	0	0	0.000000		91.01
91.02	09102 DIABETES CENTER	458,497	544,451	0.842127		91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	9,532,774	12,029,651	0.792440		92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0.000000		94.00
99.00	09900 CMHC	0	0	0.000000		99.00
99.10	09910 CORF	0	0	0.000000		99.10
101.00	10100 HOME HEALTH AGENCY	6,073,365	5,768,567	1.052838		101.00
SPECIAL PURPOSE COST CENTERS						
109.00	10900 PANCREAS ACQUISITION	0	0	0.000000		109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0.000000		110.00
111.00	11100 ISLET ACQUISITION	0	0	0.000000		111.00
200.00	Subtotal (sum of lines 50 thru 199)	252,749,185	1,101,537,284			200.00
201.00	Less Observation Beds	9,532,774	0			201.00
202.00	Total (line 200 minus line 201)	243,216,411	1,101,537,284			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part I
Date/Time Prepared:
4/29/2021 3:44 pm

		Title XVIII		Hospital		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	6,140,510	0	6,140,510	70,580	87.00	30.00
31.00	INTENSIVE CARE UNIT	1,322,313		1,322,313	8,850	149.41	31.00
33.00	BURN INTENSIVE CARE UNIT	0		0	0	0.00	33.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	SUBPROVIDER - IRF	933,619	0	933,619	8,355	111.74	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	1,386,526		1,386,526	7,289	190.22	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (lines 30 through 199)	9,782,968		9,782,968	95,074		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	26,028	2,264,436				
31.00	INTENSIVE CARE UNIT	4,091	611,236				
33.00	BURN INTENSIVE CARE UNIT	0	0				
40.00	SUBPROVIDER - IPF	0	0				
41.00	SUBPROVIDER - IRF	5,375	600,603				
42.00	SUBPROVIDER	0	0				
43.00	NURSERY	0	0				
44.00	SKILLED NURSING FACILITY	0	0				
45.00	NURSING FACILITY	0	0				
200.00	Total (lines 30 through 199)	35,494	3,476,275				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN:14-0213	Period: From 10/01/2019 To 09/30/2020	Worksheet D Part II Date/Time Prepared: 4/29/2021 3:44 pm
Title XVIII				Hospital		PPS
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	5,447,595	128,318,352	0.042454	20,281,730	861,041	50.00
51.00 05100 RECOVERY ROOM	194,119	30,148,088	0.006439	4,625,176	29,782	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	366,760	10,171,430	0.036058	14,302	516	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,609,686	167,112,972	0.015616	21,186,830	330,854	54.00
54.01 05401 ULTRASOUND	181,756	29,664,679	0.006127	4,040,795	24,758	54.01
57.00 05700 CT SCAN	526,948	100,620,414	0.005237	15,239,272	79,808	57.00
58.00 05800 MRI	173,866	28,140,241	0.006179	3,881,205	23,982	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00 06000 LABORATORY	796,415	159,074,115	0.005007	25,130,416	125,828	60.00
60.01 06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00 06300 BLOOD STORING PROCESSING & TRANS.	94,878	11,213,368	0.008461	2,838,869	24,020	63.00
65.00 06500 RESPIRATORY THERAPY	256,453	14,832,900	0.017289	5,640,568	97,520	65.00
65.01 06501 SLEEP LAB	21,789	2,971,978	0.007331	0	0	65.01
66.00 06600 PHYSICAL THERAPY	127,898	13,793,211	0.009273	4,298,718	39,862	66.00
67.00 06700 OCCUPATIONAL THERAPY	136,754	10,192,500	0.013417	954	13	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	307,805	23,990,763	0.012830	6,951,139	89,183	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	60,457	3,342,505	0.018087	440,434	7,966	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,994,082	79,245,923	0.025163	15,591,543	392,330	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1,077,959	49,511,728	0.021772	14,795,826	322,135	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,198,463	81,189,707	0.014761	18,412,644	271,789	73.00
74.00 07400 RENAL DIALYSIS	114,514	4,832,103	0.023699	2,553,205	60,508	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00 09000 CLINIC	47,911	1,775,413	0.026986	0	0	90.00
90.01 09001 HOMER GLEN LAB	0	0	0.000000	0	0	90.01
90.02 09002 HOMER GLEN FEC	0	0	0.000000	0	0	90.02
90.03 09003 WOMENS HEALTH	0	0	0.000000	0	0	90.03
91.00 09100 EMERGENCY	1,636,563	133,052,225	0.012300	17,404,163	214,071	91.00
91.01 09101 OP MENTAL HEALTH	0	0	0.000000	0	0	91.01
91.02 09102 DIABETES CENTER	17,461	544,451	0.032071	29,315	940	91.02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	814,413	12,029,651	0.067700	740,169	50,109	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00 Total (lines 50 through 199)	18,204,545	1,095,768,717		184,097,273	3,047,015	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN:14-0213		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part III Date/Time Prepared: 4/29/2021 3:44 pm	
					Title XVIII		Hospital		PPS	
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00	
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	0	33.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	41.00	
42.00	04200	SUBPROVIDER	0	0	0	0	0	0	42.00	
43.00	04300	NURSERY	0	0	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	44.00	
45.00	04500	NURSING FACILITY	0	0	0	0	0	0	45.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
					4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	70,580	0.00	26,028	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	8,850	0.00	4,091	31.00		
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0.00	0	33.00		
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00		
41.00	04100	SUBPROVIDER - IRF	0	0	8,355	0.00	5,375	41.00		
42.00	04200	SUBPROVIDER	0	0	0	0.00	0	42.00		
43.00	04300	NURSERY	0	0	7,289	0.00	0	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0.00	0	44.00		
45.00	04500	NURSING FACILITY	0	0	0	0.00	0	45.00		
200.00		Total (lines 30 through 199)	0	0	95,074	0.00	35,494	200.00		
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
					9.00					
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0					30.00		
31.00	03100	INTENSIVE CARE UNIT	0					31.00		
33.00	03300	BURN INTENSIVE CARE UNIT	0					33.00		
40.00	04000	SUBPROVIDER - IPF	0					40.00		
41.00	04100	SUBPROVIDER - IRF	0					41.00		
42.00	04200	SUBPROVIDER	0					42.00		
43.00	04300	NURSERY	0					43.00		
44.00	04400	SKILLED NURSING FACILITY	0					44.00		
45.00	04500	NURSING FACILITY	0					45.00		
200.00		Total (lines 30 through 199)	0					200.00		

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020

Worksheet D
Part IV
Date/Time Prepared:
4/29/2021 3:44 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School Post-Stepdown Adjustments	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	17,433	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	17,045	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	90.02
90.03	09003	WOMENS HEALTH	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	679,779	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
200.00		Total (lines 50 through 199)	0	0	0	714,257	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN:14-0213		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/29/2021 3:44 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	128,318,352	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	30,148,088	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	17,433	17,433	10,171,430	0.001714	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	167,112,972	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	29,664,679	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	100,620,414	0.000000	57.00
58.00	05800	MRI	0	0	0	28,140,241	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	159,074,115	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	11,213,368	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,832,900	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	2,971,978	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	13,793,211	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	10,192,500	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	17,045	17,045	23,990,763	0.000710	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	3,342,505	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	79,245,923	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	49,511,728	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	81,189,707	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,832,103	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	1,775,413	0.000000	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0.000000	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0.000000	90.02
90.03	09003	WOMENS HEALTH	0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	0	679,779	679,779	133,052,225	0.005109	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0.000000	91.01
91.02	09102	DIABETES CENTER	0	0	0	544,451	0.000000	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	12,029,651	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0.000000	94.00
200.00		Total (lines 50 through 199)	0	714,257	714,257	1,095,768,717		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN:14-0213		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/29/2021 3:44 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									
50.00	05000	OPERATING ROOM	0.000000		20,281,730	0	17,913,533	0	50.00
51.00	05100	RECOVERY ROOM	0.000000		4,625,176	0	2,945,268	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.001714		14,302	25	1,192	2	52.00
53.00	05300	ANESTHESIOLOGY	0.000000		0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		21,186,830	0	50,115,624	0	54.00
54.01	05401	ULTRASOUND	0.000000		4,040,795	0	3,578,008	0	54.01
57.00	05700	CT SCAN	0.000000		15,239,272	0	19,603,376	0	57.00
58.00	05800	MRI	0.000000		3,881,205	0	5,123,247	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000		25,130,416	0	11,004,819	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000		0	0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.000000		2,838,869	0	712,851	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000		5,640,568	0	762,068	0	65.00
65.01	06501	SLEEP LAB	0.000000		0	0	630,094	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000		4,298,718	0	13,516	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		954	0	121,469	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000710		6,951,139	4,935	3,112,346	2,210	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		440,434	0	524,200	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		15,591,543	0	10,976,902	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		14,795,826	0	5,616,647	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		18,412,644	0	8,308,633	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000		2,553,205	0	135,143	0	74.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	0	0	0	89.00
90.00	09000	CLINIC	0.000000		0	0	744,583	0	90.00
90.01	09001	HOMER GLEN LAB	0.000000		0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0.000000		0	0	0	0	90.02
90.03	09003	WOMENS HEALTH	0.000000		0	0	0	0	90.03
91.00	09100	EMERGENCY	0.005109		17,404,163	88,918	14,322,856	73,175	91.00
91.01	09101	OP MENTAL HEALTH	0.000000		0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0.000000		29,315	0	1,752	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		740,169	0	2,791,171	0	92.00
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		0	0	0	0	94.00
200.00		Total (lines 50 through 199)			184,097,273	93,878	159,059,298	75,387	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN:14-0213	Period: From 10/01/2019 To 09/30/2020	Worksheet D Part V Date/Time Prepared: 4/29/2021 3:44 pm
			Title XVIII	Hospital	PPS
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.304991	17,913,533	52,245	0	5,463,466
51.00 05100 RECOVERY ROOM	0.091584	2,945,268	0	0	269,739
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.754681	1,192	0	0	900
53.00 05300 ANESTHESIOLOGY	0.000000	0	0	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.138336	50,115,624	0	0	6,932,795
54.01 05401 ULTRASOUND	0.090051	3,578,008	0	0	322,203
57.00 05700 CT SCAN	0.039847	19,603,376	0	0	781,136
58.00 05800 MRI	0.073586	5,123,247	0	0	376,999
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00 06000 LABORATORY	0.102253	11,004,819	0	0	1,125,276
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0
63.00 06300 BLOOD STORING PROCESSING & TRANS.	0.207630	712,851	0	0	148,009
65.00 06500 RESPIRATORY THERAPY	0.303035	762,068	0	0	230,933
65.01 06501 SLEEP LAB	0.190008	630,094	0	0	119,723
66.00 06600 PHYSICAL THERAPY	0.239951	13,516	0	0	3,243
67.00 06700 OCCUPATIONAL THERAPY	0.294777	121,469	0	0	35,806
68.00 06800 SPEECH PATHOLOGY	0.000000	0	0	0	0
69.00 06900 ELECTROCARDIOLOGY	0.113984	3,112,346	0	0	354,758
70.00 07000 ELECTROENCEPHALOGRAPHY	0.151583	524,200	0	0	79,460
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.508836	10,976,902	0	0	5,585,443
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.613116	5,616,647	0	0	3,443,656
73.00 07300 DRUGS CHARGED TO PATIENTS	0.343809	8,308,633	0	52,634	2,856,583
74.00 07400 RENAL DIALYSIS	0.250981	135,143	0	0	33,918
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC					
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER					
90.00 09000 CLINIC	0.719575	744,583	0	166	535,783
90.01 09001 HOMER GLEN LAB	0.000000	0	0	0	0
90.02 09002 HOMER GLEN FEC	0.000000	0	0	0	0
90.03 09003 WOMENS HEALTH	0.000000	0	0	0	0
91.00 09100 EMERGENCY	0.157452	14,322,856	0	0	2,255,162
91.01 09101 OP MENTAL HEALTH	0.000000	0	0	0	0
91.02 09102 DIABETES CENTER	0.842127	1,752	0	0	1,475
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.792440	2,791,171	0	0	2,211,836
OTHER REIMBURSABLE COST CENTERS					
94.00 09400 HOME PROGRAM DIALYSIS	0.000000		0	0	
200.00 Subtotal (see instructions)		159,059,298	52,245	52,800	33,168,302
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	
202.00 Net Charges (line 200 - line 201)		159,059,298	52,245	52,800	33,168,302

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN:14-0213	Period: From 10/01/2019 To 09/30/2020	Worksheet D Part V Date/Time Prepared: 4/29/2021 3:44 pm
			Title XVIII	Hospital	PPS
Cost Center Description			Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	15,934	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	ULTRASOUND	0	0	54.01
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
65.01	06501	SLEEP LAB	0	0	65.01
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
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	18,096	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000	CLINIC	0	119	90.00
90.01	09001	HOMER GLEN LAB	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	90.02
90.03	09003	WOMENS HEALTH	0	0	90.03
91.00	09100	EMERGENCY	0	0	91.00
91.01	09101	OP MENTAL HEALTH	0	0	91.01
91.02	09102	DIABETES CENTER	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0	0	94.00
200.00		Subtotal (see instructions)	15,934	18,215	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	15,934	18,215	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN:14-0213	Period: From 10/01/2019 To 09/30/2020	Worksheet D Part II Date/Time Prepared: 4/29/2021 3:44 pm
				Component CCN:14-T213		
				Title XVIII	Subprovider - IR#	PPS
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	5,447,595	128,318,352	0.042454	6,430	273	50.00
51.00 05100 RECOVERY ROOM	194,119	30,148,088	0.006439	23	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	366,760	10,171,430	0.036058	1	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,609,686	167,112,972	0.015616	98,351	1,536	54.00
54.01 05401 ULTRASOUND	181,756	29,664,679	0.006127	100,302	615	54.01
57.00 05700 CT SCAN	526,948	100,620,414	0.005237	147,669	773	57.00
58.00 05800 MRI	173,866	28,140,241	0.006179	63,751	394	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00 06000 LABORATORY	796,415	159,074,115	0.005007	985,236	4,933	60.00
60.01 06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00 06300 BLOOD STORING PROCESSING & TRANS.	94,878	11,213,368	0.008461	62,659	530	63.00
65.00 06500 RESPIRATORY THERAPY	256,453	14,832,900	0.017289	261,220	4,516	65.00
65.01 06501 SLEEP LAB	21,789	2,971,978	0.007331	0	0	65.01
66.00 06600 PHYSICAL THERAPY	127,898	13,793,211	0.009273	3,154,707	29,254	66.00
67.00 06700 OCCUPATIONAL THERAPY	136,754	10,192,500	0.013417	404	5	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	307,805	23,990,763	0.012830	26,065	334	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	60,457	3,342,505	0.018087	7,690	139	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,994,082	79,245,923	0.025163	291,857	7,344	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1,077,959	49,511,728	0.021772	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,198,463	81,189,707	0.014761	628,281	9,274	73.00
74.00 07400 RENAL DIALYSIS	114,514	4,832,103	0.023699	169,905	4,027	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00 09000 CLINIC	47,911	1,775,413	0.026986	0	0	90.00
90.01 09001 HOMER GLEN LAB	0	0	0.000000	0	0	90.01
90.02 09002 HOMER GLEN FEC	0	0	0.000000	0	0	90.02
90.03 09003 WOMENS HEALTH	0	0	0.000000	0	0	90.03
91.00 09100 EMERGENCY	1,636,563	133,052,225	0.012300	176	2	91.00
91.01 09101 OP MENTAL HEALTH	0	0	0.000000	0	0	91.01
91.02 09102 DIABETES CENTER	17,461	544,451	0.032071	2,641	85	91.02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	12,029,651	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00 Total (lines 50 through 199)	17,390,132	1,095,768,717		6,007,368	64,034	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:14-0213

Period:

Worksheet D

Component CCN:14-T213

From 10/01/2019

Part IV

To 09/30/2020

Date/Time Prepared:

4/29/2021 3:44 pm

Cost Center Description		Title XVIII		Subprovider - IR#		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School Post-Stepdown Adjustments	Allied Health Post-Stepdown Adjustments	Allied Health Post-Stepdown Adjustments	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	17,433	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	17,045	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	90.02
90.03	09003	WOMENS HEALTH	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	679,779	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
200.00		Total (lines 50 through 199)	0	0	0	714,257	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:14-0213

Period:

Worksheet D

Component CCN:14-T213

From 10/01/2019

Part IV

To 09/30/2020

Date/Time Prepared:

4/29/2021 3:44 pm

			Title XVIII		Subprovider - IR#		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	128,318,352	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	30,148,088	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	17,433	17,433	10,171,430	0.001714	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	167,112,972	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	29,664,679	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	100,620,414	0.000000	57.00
58.00	05800	MRI	0	0	0	28,140,241	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	159,074,115	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	11,213,368	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,832,900	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	2,971,978	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	13,793,211	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	10,192,500	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	17,045	17,045	23,990,763	0.000710	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	3,342,505	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	79,245,923	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	49,511,728	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	81,189,707	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,832,103	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	1,775,413	0.000000	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0.000000	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0.000000	90.02
90.03	09003	WOMENS HEALTH	0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	0	679,779	679,779	133,052,225	0.005109	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0.000000	91.01
91.02	09102	DIABETES CENTER	0	0	0	544,451	0.000000	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	12,029,651	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0.000000	94.00
200.00		Total (lines 50 through 199)	0	714,257	714,257	1,095,768,717		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:14-0213

Period:

Worksheet D

Component CCN:14-T213

From 10/01/2019

Part IV

To 09/30/2020

Date/Time Prepared:

4/29/2021 3:44 pm

Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	6,430	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	23	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.001714	1	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	98,351	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	100,302	0	0	0	54.01
57.00	05700	CT SCAN	0.000000	147,669	0	0	0	57.00
58.00	05800	MRI	0.000000	63,751	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	985,236	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.000000	62,659	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	261,220	0	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	3,154,707	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	404	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000710	26,065	19	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	7,690	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	291,857	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	628,281	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	169,905	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0.000000	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0.000000	0	0	0	0	90.02
90.03	09003	WOMENS HEALTH	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.005109	176	1	0	0	91.00
91.01	09101	OP MENTAL HEALTH	0.000000	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0.000000	2,641	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00
200.00		Total (lines 50 through 199)		6,007,368	20	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part I
Date/Time Prepared:
4/29/2021 3:44 pm

			Title XIX		Hospital	PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	6,140,510	0	6,140,510	70,580	87.00	30.00	
31.00	INTENSIVE CARE UNIT	1,322,313		1,322,313	8,850	149.41	31.00	
33.00	BURN INTENSIVE CARE UNIT	0		0	0	0.00	33.00	
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00	
41.00	SUBPROVIDER - IRF	933,619	0	933,619	8,355	111.74	41.00	
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00	
43.00	NURSERY	1,386,526		1,386,526	7,289	190.22	43.00	
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00	
45.00	NURSING FACILITY	0		0	0	0.00	45.00	
200.00	Total (lines 30 through 199)	9,782,968		9,782,968	95,074		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,723	236,901					30.00
31.00	INTENSIVE CARE UNIT	394	58,868					31.00
33.00	BURN INTENSIVE CARE UNIT	0	0					33.00
40.00	SUBPROVIDER - IPF	0	0					40.00
41.00	SUBPROVIDER - IRF	155	17,320					41.00
42.00	SUBPROVIDER	0	0					42.00
43.00	NURSERY	324	61,631					43.00
44.00	SKILLED NURSING FACILITY	0	0					44.00
45.00	NURSING FACILITY	0	0					45.00
200.00	Total (lines 30 through 199)	3,596	374,720					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN:14-0213	Period: From 10/01/2019 To 09/30/2020	Worksheet D Part II Date/Time Prepared: 4/29/2021 3:44 pm
Title XIX				Hospital	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	5,447,595	128,318,352	0.042454	0	0	50.00
51.00 05100 RECOVERY ROOM	194,119	30,148,088	0.006439	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	366,760	10,171,430	0.036058	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,609,686	167,112,972	0.015616	0	0	54.00
54.01 05401 ULTRASOUND	181,756	29,664,679	0.006127	0	0	54.01
57.00 05700 CT SCAN	526,948	100,620,414	0.005237	0	0	57.00
58.00 05800 MRI	173,866	28,140,241	0.006179	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00 06000 LABORATORY	796,415	159,074,115	0.005007	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00 06300 BLOOD STORING PROCESSING & TRANS.	94,878	11,213,368	0.008461	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	256,453	14,832,900	0.017289	0	0	65.00
65.01 06501 SLEEP LAB	21,789	2,971,978	0.007331	0	0	65.01
66.00 06600 PHYSICAL THERAPY	127,898	13,793,211	0.009273	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	136,754	10,192,500	0.013417	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	307,805	23,990,763	0.012830	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	60,457	3,342,505	0.018087	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,994,082	79,245,923	0.025163	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1,077,959	49,511,728	0.021772	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,198,463	81,189,707	0.014761	0	0	73.00
74.00 07400 RENAL DIALYSIS	114,514	4,832,103	0.023699	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00 09000 CLINIC	47,911	1,775,413	0.026986	0	0	90.00
90.01 09001 HOMER GLEN LAB	0	0	0.000000	0	0	90.01
90.02 09002 HOMER GLEN FEC	0	0	0.000000	0	0	90.02
90.03 09003 WOMENS HEALTH	0	0	0.000000	0	0	90.03
91.00 09100 EMERGENCY	1,636,563	133,052,225	0.012300	0	0	91.00
91.01 09101 OP MENTAL HEALTH	0	0	0.000000	0	0	91.01
91.02 09102 DIABETES CENTER	17,461	544,451	0.032071	0	0	91.02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	814,413	12,029,651	0.067700	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00 Total (lines 50 through 199)	18,204,545	1,095,768,717		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN:14-0213		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part III Date/Time Prepared: 4/29/2021 3:44 pm	
					Title XIX		Hospital		PPS	
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00	
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	0	33.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	41.00	
42.00	04200	SUBPROVIDER	0	0	0	0	0	0	42.00	
43.00	04300	NURSERY	0	0	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	44.00	
45.00	04500	NURSING FACILITY	0	0	0	0	0	0	45.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
					4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	70,580	0.00	2,723	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	8,850	0.00	394	31.00		
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0.00	0	33.00		
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00		
41.00	04100	SUBPROVIDER - IRF	0	0	8,355	0.00	155	41.00		
42.00	04200	SUBPROVIDER	0	0	0	0.00	0	42.00		
43.00	04300	NURSERY	0	0	7,289	0.00	324	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0.00	0	44.00		
45.00	04500	NURSING FACILITY	0	0	0	0.00	0	45.00		
200.00		Total (lines 30 through 199)	0	0	95,074	0.00	3,596	200.00		
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
					9.00					
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0					30.00		
31.00	03100	INTENSIVE CARE UNIT	0					31.00		
33.00	03300	BURN INTENSIVE CARE UNIT	0					33.00		
40.00	04000	SUBPROVIDER - IPF	0					40.00		
41.00	04100	SUBPROVIDER - IRF	0					41.00		
42.00	04200	SUBPROVIDER	0					42.00		
43.00	04300	NURSERY	0					43.00		
44.00	04400	SKILLED NURSING FACILITY	0					44.00		
45.00	04500	NURSING FACILITY	0					45.00		
200.00		Total (lines 30 through 199)	0					200.00		

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020

Worksheet D
Part IV
Date/Time Prepared:
4/29/2021 3:44 pm

Cost Center Description		Title XIX		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School Post-Stepdown Adjustments	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	17,433	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	17,045	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	90.02
90.03	09003	WOMENS HEALTH	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	679,779	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
200.00		Total (lines 50 through 199)	0	0	0	714,257	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN:14-0213		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/29/2021 3:44 pm	
			Title XIX		Hospital		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	128,318,352	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	30,148,088	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	17,433	17,433	10,171,430	0.001714	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	167,112,972	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	29,664,679	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	100,620,414	0.000000	57.00
58.00	05800	MRI	0	0	0	28,140,241	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	159,074,115	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	11,213,368	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,832,900	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	2,971,978	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	13,793,211	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	10,192,500	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	17,045	17,045	23,990,763	0.000710	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	3,342,505	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	79,245,923	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	49,511,728	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	81,189,707	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,832,103	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	1,775,413	0.000000	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0.000000	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0.000000	90.02
90.03	09003	WOMENS HEALTH	0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	0	679,779	679,779	133,052,225	0.005109	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0.000000	91.01
91.02	09102	DIABETES CENTER	0	0	0	544,451	0.000000	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	12,029,651	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0.000000	94.00
200.00		Total (lines 50 through 199)	0	714,257	714,257	1,095,768,717		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020

Worksheet D
Part IV
Date/Time Prepared:
4/29/2021 3:44 pm

Cost Center Description			Title XIX		Hospital		PPS	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.001714	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01
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
69.00	06900	ELECTROCARDIOLOGY	0.000710	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
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
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0.000000	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0.000000	0	0	0	0	90.02
90.03	09003	WOMENS HEALTH	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.005109	0	0	0	0	91.00
91.01	09101	OP MENTAL HEALTH	0.000000	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0.000000	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN:14-0213	Period: From 10/01/2019 To 09/30/2020	Worksheet D Part II Date/Time Prepared: 4/29/2021 3:44 pm
				Component CCN:14-T213		
				Title XIX	Subprovider - IR#	PPS
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	5,447,595	128,318,352	0.042454	0	0	50.00
51.00 05100 RECOVERY ROOM	194,119	30,148,088	0.006439	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	366,760	10,171,430	0.036058	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,609,686	167,112,972	0.015616	0	0	54.00
54.01 05401 ULTRASOUND	181,756	29,664,679	0.006127	0	0	54.01
57.00 05700 CT SCAN	526,948	100,620,414	0.005237	0	0	57.00
58.00 05800 MRI	173,866	28,140,241	0.006179	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00 06000 LABORATORY	796,415	159,074,115	0.005007	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00 06300 BLOOD STORING PROCESSING & TRANS.	94,878	11,213,368	0.008461	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	256,453	14,832,900	0.017289	0	0	65.00
65.01 06501 SLEEP LAB	21,789	2,971,978	0.007331	0	0	65.01
66.00 06600 PHYSICAL THERAPY	127,898	13,793,211	0.009273	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	136,754	10,192,500	0.013417	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	307,805	23,990,763	0.012830	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	60,457	3,342,505	0.018087	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,994,082	79,245,923	0.025163	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1,077,959	49,511,728	0.021772	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,198,463	81,189,707	0.014761	0	0	73.00
74.00 07400 RENAL DIALYSIS	114,514	4,832,103	0.023699	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00 09000 CLINIC	47,911	1,775,413	0.026986	0	0	90.00
90.01 09001 HOMER GLEN LAB	0	0	0.000000	0	0	90.01
90.02 09002 HOMER GLEN FEC	0	0	0.000000	0	0	90.02
90.03 09003 WOMENS HEALTH	0	0	0.000000	0	0	90.03
91.00 09100 EMERGENCY	1,636,563	133,052,225	0.012300	0	0	91.00
91.01 09101 OP MENTAL HEALTH	0	0	0.000000	0	0	91.01
91.02 09102 DIABETES CENTER	17,461	544,451	0.032071	0	0	91.02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	12,029,651	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00 Total (lines 50 through 199)	17,390,132	1,095,768,717		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:14-0213

Period:

Worksheet D

Component CCN:14-T213

From 10/01/2019
To 09/30/2020Part IV
Date/Time Prepared:
4/29/2021 3:44 pm

				Title XIX		Subprovider - IR#		PPS	
Cost Center Description			Non Physician	Nursing School	Nursing School	Allied Health	Allied Health		
			Anesthetist Cost	Post-Stepdown Adjustments		Post-Stepdown Adjustments			
			1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00	
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	17,433	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01	
57.00	05700	CT SCAN	0	0	0	0	0	57.00	
58.00	05800	MRI	0	0	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00	06000	LABORATORY	0	0	0	0	0	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01	
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	0	0	63.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00	
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01	
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	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	17,045	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00	
90.00	09000	CLINIC	0	0	0	0	0	90.00	
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01	
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02	
90.03	09003	WOMENS HEALTH	0	0	0	0	0	90.03	
91.00	09100	EMERGENCY	0	0	0	0	679,779	91.00	
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0	91.01	
91.02	09102	DIABETES CENTER	0	0	0	0	0	91.02	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00	
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00	
200.00		Total (lines 50 through 199)	0	0	0	0	714,257	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:14-0213

Period:

Worksheet D

Component CCN:14-T213

From 10/01/2019

Part IV

To 09/30/2020

Date/Time Prepared:

4/29/2021 3:44 pm

Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	128,318,352	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	30,148,088	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	17,433	17,433	10,171,430	0.001714	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	167,112,972	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	29,664,679	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	100,620,414	0.000000	57.00
58.00	05800	MRI	0	0	0	28,140,241	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	159,074,115	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	11,213,368	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,832,900	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	2,971,978	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	13,793,211	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	10,192,500	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	17,045	17,045	23,990,763	0.000710	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	3,342,505	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	79,245,923	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	49,511,728	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	81,189,707	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,832,103	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	1,775,413	0.000000	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0.000000	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0.000000	90.02
90.03	09003	WOMENS HEALTH	0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	0	679,779	679,779	133,052,225	0.005109	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0.000000	91.01
91.02	09102	DIABETES CENTER	0	0	0	544,451	0.000000	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	12,029,651	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0.000000	94.00
200.00		Total (lines 50 through 199)	0	714,257	714,257	1,095,768,717		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:14-0213

Period:

Worksheet D

Component CCN:14-T213

From 10/01/2019
To 09/30/2020Part IV
Date/Time Prepared:
4/29/2021 3:44 pm

Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.001714	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
54.01	05401 ULTRASOUND	0.000000	0	0	0	0	54.01
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MRI	0.000000	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300 BLOOD STORING PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
65.01	06501 SLEEP LAB	0.000000	0	0	0	0	65.01
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
69.00	06900 ELECTROCARDIOLOGY	0.000710	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
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
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	09001 HOMER GLEN LAB	0.000000	0	0	0	0	90.01
90.02	09002 HOMER GLEN FEC	0.000000	0	0	0	0	90.02
90.03	09003 WOMENS HEALTH	0.000000	0	0	0	0	90.03
91.00	09100 EMERGENCY	0.005109	0	0	0	0	91.00
91.01	09101 OP MENTAL HEALTH	0.000000	0	0	0	0	91.01
91.02	09102 DIABETES CENTER	0.000000	0	0	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00
200.00	Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN:14-0213	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/29/2021 3:44 pm
		Title XVIII	Hospital	PPS
Cost Center Description				
				1.00
	PART I - ALL PROVIDER COMPONENTS			
	INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		70,580	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		70,580	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)		61,219	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)		26,028	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)		71,875,389	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)		71,875,389	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)		71,875,389	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)		1,018.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		26,505,614	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)		26,505,614	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020

Worksheet D-1

Date/Time Prepared:
4/29/2021 3:44 pm

		Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	17,864,911	8,850	2,018.63	4,091	8,258,215
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					44,939,442
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					79,703,271
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and II)					1,175,672
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts III and IV)					1,140,893
52.00	Total Program excludable cost (sum of lines 50 and 51)					6,016,565
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					21,686,706
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					9,361
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,018.35
89.00	Observation bed cost (line 87 x line 88) (see instructions)					9,532,774

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN:14-0213		Period: From 10/01/2019 To 09/30/2020		Worksheet D-1 Date/Time Prepared: 4/29/2021 3:44 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)			
		1.00	2.00	3.00	4.00	5.00			
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
90.00	Capital-related cost	6,140,510	71,875,389	0.085433	9,532,774	814,413	90.00		
91.00	Nursing School cost	0	71,875,389	0.000000	9,532,774	0	91.00		
92.00	Allied health cost	0	71,875,389	0.000000	9,532,774	0	92.00		
93.00	All other Medical Education	0	71,875,389	0.000000	9,532,774	0	93.00		

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN:14-0213	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1
		Component CCN:14-T213		Date/Time Prepared: 4/29/2021 3:44 pm
		Title XVIII	Subprovider - IR#	PPS
Cost Center Description				
				1.00
	PART I - ALL PROVIDER COMPONENTS			
	INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		8,355	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		8,355	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)		8,355	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)		5,375	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)		10,533,809	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)		10,533,809	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)		10,533,809	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)		1,260.78	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		6,776,693	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)		6,776,693	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN:14-0213 Component CCN:14-T213	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/29/2021 3:44 pm			
			Title XVIII		Subprovider - IR#	PPS		
Cost Center Description			Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
			1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)		0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT		0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT							44.00
45.00	BURN INTENSIVE CARE UNIT		0	0	0.00	0	0	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)						1,399,562	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						8,176,255	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)						00,603	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						64,054	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						664,657	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						1,511,598	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:14-0213

Period:

Worksheet D-1

Component CCN:14-T213

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/29/2021 3:44 pm

Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	933,619	10,533,809	0.088631	0	0	90.00
91.00	Nursing School cost	0	10,533,809	0.000000	0	0	91.00
92.00	Allied health cost	0	10,533,809	0.000000	0	0	92.00
93.00	All other Medical Education	0	10,533,809	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN:14-0213	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/29/2021 3:44 pm
		Title XIX	Hospital	PPS
Cost Center Description				
				1.00
	PART I - ALL PROVIDER COMPONENTS			
	INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		70,580	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		70,580	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)		61,219	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		2,723	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)		7,289	15.00
16.00	Nursery days (title V or XIX only)		324	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)		71,875,389	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)		71,875,389	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)		71,875,389	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)		1,018.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,772,967	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,772,967	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN:14-0213	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/29/2021 3:44 pm
			Title XIX	Hospital	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
42.00 NURSERY (title V & XIX only)	9,546,586	7,289	1,309.73	324	424,353
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	17,864,911	8,850	2,018.63	394	795,340
44.00 CORONARY CARE UNIT					
45.00 BURN INTENSIVE CARE UNIT	0	0	0.00	0	0
46.00 SURGICAL INTENSIVE CARE UNIT					
47.00 OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,992,660
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					357,400
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00 Total Program excludable cost (sum of lines 50 and 51)					357,400
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,635,260
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					9,361
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,018.35
89.00 Observation bed cost (line 87 x line 88) (see instructions)					9,532,774

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020

Worksheet D-1

Date/Time Prepared:
4/29/2021 3:44 pm

		Title XIX		Hospital	PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	6,140,510	71,875,389	0.085433	9,532,774	814,413
91.00	Nursing School cost	0	71,875,389	0.000000	9,532,774	0
92.00	Allied health cost	0	71,875,389	0.000000	9,532,774	0
93.00	All other Medical Education	0	71,875,389	0.000000	9,532,774	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN:14-0213	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1
		Component CCN:14-T213		Date/Time Prepared: 4/29/2021 3:44 pm
		Title XIX	Subprovider - IR#	PPS
Cost Center Description				
				1.00
	PART I - ALL PROVIDER COMPONENTS			
	INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		8,355	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		8,355	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)		8,355	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)		155	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)		7,289	15.00
16.00	Nursery days (title V or XIX only)		324	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)		10,533,809	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)		10,533,809	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)		10,533,809	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)		1,260.78	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		195,421	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)		195,421	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN:14-0213 Component CCN:14-T213	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/29/2021 3:44 pm	
				Title XIX		Subprovider - IR# PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	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)					195,421	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)					17,320	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)					17,320	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					178,101	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:14-0213

Period:

Worksheet D-1

Component CCN:14-T213

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/29/2021 3:44 pm

Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	933,619	10,533,809	0.088631	0	0	90.00
91.00	Nursing School cost	0	10,533,809	0.000000	0	0	91.00
92.00	Allied health cost	0	10,533,809	0.000000	0	0	92.00
93.00	All other Medical Education	0	10,533,809	0.000000	0	0	93.00

Health Financial Systems		SILVER CROSS HOSPITAL		In Lieu of Form CMS-2552-10	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN:14-0213	Period: From 10/01/2019 To 09/30/2020	Worksheet D-3 Date/Time Prepared: 4/29/2021 3:44 pm
			Title XVIII	Hospital	PPS
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		34,428,421	30.00
31.00	03100	INTENSIVE CARE UNIT		10,384,038	31.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	33.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.305127	20,281,730	50.00
51.00	05100	RECOVERY ROOM	0.091584	4,625,176	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.754681	14,302	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.138826	21,186,830	54.00
54.01	05401	ULTRASOUND	0.090051	4,040,795	54.01
57.00	05700	CT SCAN	0.039847	15,239,272	57.00
58.00	05800	MRI	0.073586	3,881,205	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.102746	25,130,416	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.207630	2,838,869	63.00
65.00	06500	RESPIRATORY THERAPY	0.303178	5,640,568	65.00
65.01	06501	SLEEP LAB	0.190008	0	65.01
66.00	06600	PHYSICAL THERAPY	0.239951	4,298,718	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.294777	954	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.114650	6,951,139	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.162640	440,434	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.508836	15,591,543	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.613116	14,795,826	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.343809	18,412,644	73.00
74.00	07400	RENAL DIALYSIS	0.251905	2,553,205	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.720007	0	90.00
90.01	09001	HOMER GLEN LAB	0.000000	0	90.01
90.02	09002	HOMER GLEN FEC	0.000000	0	90.02
90.03	09003	WOMENS HEALTH	0.000000	0	90.03
91.00	09100	EMERGENCY	0.157819	17,404,163	91.00
91.01	09101	OP MENTAL HEALTH	0.000000	0	91.01
91.02	09102	DIABETES CENTER	0.842127	29,315	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.792440	740,169	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	94.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		184,097,273	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		184,097,273	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN:14-0213

Period:

Worksheet D-3

Component CCN:14-T213

From 10/01/2019

Date/Time Prepared:

To 09/30/2020

4/29/2021 3:44 pm

Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
Title XVIII Subprovider - IRF PPS						
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
33.00	03300	BURN INTENSIVE CARE UNIT		0		33.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		10,201,080		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.305127	6,430	1,962	50.00
51.00	05100	RECOVERY ROOM	0.091584	23	2	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.754681	1	1	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.138826	98,351	13,654	54.00
54.01	05401	ULTRASOUND	0.090051	100,302	9,032	54.01
57.00	05700	CT SCAN	0.039847	147,669	5,884	57.00
58.00	05800	MRI	0.073586	63,751	4,691	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.102746	985,236	101,229	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.207630	62,659	13,010	63.00
65.00	06500	RESPIRATORY THERAPY	0.303178	261,220	79,196	65.00
65.01	06501	SLEEP LAB	0.190008	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.239951	3,154,707	756,975	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.294777	404	119	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.114650	26,065	2,988	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.162640	7,690	1,251	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.508836	291,857	148,507	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.613116	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.343809	628,281	216,009	73.00
74.00	07400	RENAL DIALYSIS	0.251905	169,905	42,800	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.720007	0	0	90.00
90.01	09001	HOMER GLEN LAB	0.000000	0	0	90.01
90.02	09002	HOMER GLEN FEC	0.000000	0	0	90.02
90.03	09003	WOMENS HEALTH	0.000000	0	0	90.03
91.00	09100	EMERGENCY	0.157819	176	28	91.00
91.01	09101	OP MENTAL HEALTH	0.000000	0	0	91.01
91.02	09102	DIABETES CENTER	0.842127	2,641	2,224	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.792440	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		6,007,368	1,399,562	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		6,007,368		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-0213	Period: From 10/01/2019 To 09/30/2020	Worksheet E Part A Date/Time Prepared: 4/29/2021 3:44 pm
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		919,864	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		467,280	2.04
3.00	Managed Care Simulated Payments		20,606,204	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		248.07	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.07	30.00
31.00	Percentage of Medicaid patient days (see instructions)		15.01	31.00
32.00	Sum of lines 30 and 31		17.08	32.00
33.00	Allowable disproportionate share percentage (see instructions)		3.85	33.00
34.00	Disproportionate share adjustment (see instructions)		634,479	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-0213	Period: From 10/01/2019 To 09/30/2020	Worksheet E Part A Date/Time Prepared: 4/29/2021 3:44 pm	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	2,482,579	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	2,482,579	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		2,482,579		36.00
40.00	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)	69,504,202			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
			Amount		
			1.00		
49.00	Total payment for inpatient operating costs (see instructions)		69,504,202		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		5,494,055		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		46,369		53.00
54.00	Special add-on payments for new technologies		0		54.00
54.01	Islet isolation add-on payment		0		54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		93,878		58.00
59.00	Total (sum of amounts on lines 49 through 58)		75,138,504		59.00
60.00	Primary payer payments		47,236		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		75,091,268		61.00
62.00	Deductibles billed to program beneficiaries		6,935,720		62.00
63.00	Coinsurance billed to program beneficiaries		120,043		63.00
64.00	Allowable bad debts (see instructions)		863,503		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		561,277		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		370,733		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		68,596,782		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0		70.50
70.87	Demonstration payment adjustment amount before sequestration		0		70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0		70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		144,200		70.93
70.94	HRR adjustment amount (see instructions)		-85,694		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-0213	Period: From 10/01/2019 To 09/30/2020	Worksheet E Part A Date/Time Prepared: 4/29/2021 3:44 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		68,655,288	71.00
71.01	Sequestration adjustment (see instructions)		796,401	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		67,935,391	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-76,504	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		2,354,405	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
4/29/2021 3:44 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	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	65,919,864	0		65,919,864	65,919,864	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	467,280	0		467,280	467,280	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	20,606,204	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0385	0.0385	0.0385	0.0385		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	634,479	0	0	634,479	634,479	11.00
11.01	Uncompensated care payments	36.00	2,482,579	0	0	2,482,579	2,482,579	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	69,504,202	0	0	69,504,202	69,504,202	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	69,504,202	0	0	69,504,202	69,504,202	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	5,494,055	0	0	5,494,055	5,494,055	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ acquisition cost							17.01

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
4/29/2021 3:44 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		
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00	
19.00	SUBTOTAL			0	0	74,998,257	74,998,257	19.00	
		W/S L, line	(Amounts from L)						
		0	1.00	2.00	3.00	4.00	5.00		
20.00	Capital DRG other than outlier	1.00	5,213,211	0	0	5,213,211	5,213,211	20.00	
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01	
21.00	Capital DRG outlier payments	2.00	97,339	0	0	97,339	97,339	21.00	
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01	
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00	
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0352	0.0352	0.0352	0.0352		24.00	
25.00	Disproportionate share adjustment (see instructions)	11.00	183,505	0	0	183,505	183,505	25.00	
26.00	Total prospective capital payments (see instructions)	12.00	5,494,055	0	0	5,494,055	5,494,055	26.00	
		W/S E, Part A line	(Amounts to E, Part A)						
		0	1.00	2.00	3.00	4.00	5.00		
27.00	Low volume adjustment factor				0.000000	0.000000		27.00	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00	
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00	
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00	

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
4/29/2021 3:44 pm

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	65,919,864		65,919,864	65,919,864	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	467,280		467,280	467,280	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	20,606,204	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0385	0.0385	0.0385		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	634,479	0	634,479	634,479	11.00
11.01	Uncompensated care payments	36.00	2,482,579	0	2,482,579	2,482,579	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	69,504,202	0	69,504,202	69,504,202	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	69,504,202	0	69,504,202	69,504,202	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	5,494,055	0	5,494,055	5,494,055	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			0	74,998,257	74,998,257	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5			Provider CCN:14-0213	Period: From 10/01/2019 To 09/30/2020	Worksheet E Part A Exhibit 5 Date/Time Prepared: 4/29/2021 3:44 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	5,213,211	0	5,213,211	5,213,211	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	97,339	0	97,339	97,339	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	0.0352	0.0352	0.0352		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	183,505	0	183,505	183,505	25.00
26.00	Total prospective capital payments (see instructions)	12.00	5,494,055	0	5,494,055	5,494,055	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	144,200	0	144,200	144,200	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	-85,694	0	-85,694	-85,694	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

Health Financial Systems		SILVER CROSS HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-0213	Period: From 10/01/2019 To 09/30/2020	Worksheet E Part B Date/Time Prepared: 4/29/2021 3:44 pm	
		Title XVIII	Hospital	PPS	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)			34,149	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			33,092,915	2.00
3.00	OPPS payments			32,814,167	3.00
4.00	Outlier payment (see instructions)			14,951	4.00
4.01	Outlier reconciliation amount (see instructions)			0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000	5.00
6.00	Line 2 times line 5			0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
8.00	Transitional corridor payment (see instructions)			0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			75,387	9.00
10.00	Organ acquisitions			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			34,149	11.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges			105,045	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)			105,045	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 charge basis 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)			105,045	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			70,896	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)			34,149	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)			32,904,505	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			10,449	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			5,715,034	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)			27,213,171	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0	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)			27,213,171	30.00
31.00	Primary payer payments			2,177	31.00
32.00	Subtotal (line 30 minus line 31)			27,210,994	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)			483,890	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			314,529	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			231,673	36.00
37.00	Subtotal (see instructions)			27,525,523	37.00
38.00	MSP-LCC reconciliation amount from PS&R			-134	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)			27,525,657	40.00
40.01	Sequestration adjustment (see instructions)			319,298	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			27,377,776	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)			-171,417	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			566,808	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-0213	Period: From 10/01/2019 To 09/30/2020	Worksheet E Part B Date/Time Prepared: 4/29/2021 3:44 pm
		Component CCN:14-T213		
		Title XVIII	Subprovider - IR#	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 OPPI (see instructions)		0	2.00
3.00	OPPI payments		0	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)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		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 charge basis 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)		0	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)		0	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)		0	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	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)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		0	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		0	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03	
41.00	Interim payments		0	41.00
41.01	Interim payments-PARHM		41.01	
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01	
43.00	Balance due provider/program (see instructions)		0	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01	
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		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:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet E-1
Part I
Date/Time Prepared:
4/29/2021 3:44 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		67,864,260		27,377,776	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		0		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	05/13/2020	71,131		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		71,131		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)		67,935,391		27,377,776	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		76,504		171,417	6.02
7.00	Total Medicare program liability (see instructions)		67,858,887		27,206,359	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN:14-0213

Period:

Worksheet E-1

Component CCN:14-T213

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
4/29/2021 3:44 pm

		Title XVIII		Subprovider - IR#		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		9,800,980		0	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		0		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	05/13/2020	20,918		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		20,918		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)		9,821,898		0	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		63,761		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		9,885,659		0	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:14-0213	Period: From 10/01/2019 To 09/30/2020	Worksheet E-1 Part II Date/Time Prepared: 4/29/2021 3:44 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, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-0213	Period: From 10/01/2019 To 09/30/2020	Worksheet E-3 Part III Date/Time Prepared: 4/29/2021 3:44 pm
		Component CCN:14-T213		
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)		9,798,176	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0.0123	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		154,811	3.00
4.00	Outlier Payments		89,058	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)		0.00	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)		0.00	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)		0.00	9.00
10.00	Average Daily Census (see instructions)		22.827869	10.00
11.00	Teaching Adjustment Factor (see instructions)		0.000000	11.00
12.00	Teaching Adjustment (see instructions)		0	12.00
13.00	Total PPS Payment (see instructions)		10,042,045	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)		10,042,045	17.00
18.00	Primary payer payments		0	18.00
19.00	Subtotal (line 17 less line 18).		10,042,045	19.00
20.00	Deductibles		15,356	20.00
21.00	Subtotal (line 19 minus line 20)		10,026,689	21.00
22.00	Coinsurance		25,696	22.00
23.00	Subtotal (line 21 minus line 22)		10,000,993	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		1,023	24.00
25.00	Adjusted reimbursable bad debts (see instructions)		665	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	26.00
27.00	Subtotal (sum of lines 23 and 25)		10,001,658	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	28.00
29.00	Other pass through costs (see instructions)		20	29.00
30.00	Outlier payments reconciliation		0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	31.50
31.99	Demonstration payment adjustment amount before sequestration		0	31.99
32.00	Total amount payable to the provider (see instructions)		10,001,678	32.00
32.01	Sequestration adjustment (see instructions)		116,019	32.01
32.02	Demonstration payment adjustment amount after sequestration		0	32.02
33.00	Interim payments		9,821,898	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)		63,761	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4		89,058	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

Health Financial Systems		SILVER CROSS HOSPITAL		In Lieu of Form CMS-2552-10	
DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN:14-0213	Period: From 10/01/2019 To 09/30/2020	Worksheet E-4 Date/Time Prepared: 4/29/2021 3:44 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.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.00	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	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	0.00	0.00	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	0.00	0.00	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	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.00	0.00		17.00
18.00	Per resident amount	0.00	0.00		18.00
19.00	Approved amount for resident costs	0	0	0	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 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)			0	25.00
		Inpatient Part A	Managed Care	Total	
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3, column 2)	02, 35,494	11,103		26.00
27.00	Total Inpatient Days (see instructions)	80,334	80,334		27.00
28.00	Ratio of inpatient days to total inpatient days	0.441830	0.138210		28.00
29.00	Program direct GME amount	0	0	0	29.00
29.01	Percent reduction for MA DGME				29.01
30.00	Reduction for direct GME payments for Medicare Advantage		0	0	30.00
31.00	Net Program direct GME amount			0	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN:14-0213	Period: From 10/01/2019 To 09/30/2020	Worksheet E-4 Date/Time Prepared: 4/29/2021 3:44 pm	
		Title XVIII	Hospital	PPS	
				1.00	
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)					
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		4,832,103		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)		87,879,526		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)		47,236		40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		87,832,290		41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)		33,202,451		42.00
43.00	Primary payer payments (see instructions)		2,177		43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		33,200,274		44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		121,032,564		45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.725691		46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.274309		47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			0	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			0	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			0	50.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)		Provider CCN:14-0213		Period: From 10/01/2019 To 09/30/2020		Worksheet G Date/Time Prepared: 4/29/2021 3:44 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	29,260,000	0	0	0	1.00	
2.00	Temporary investments	2,250,000	0	0	0	2.00	
3.00	Notes receivable	0	0	0	0	3.00	
4.00	Accounts receivable	45,892,000	0	0	0	4.00	
5.00	Other receivable	787,000	0	0	0	5.00	
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00	
7.00	Inventory	0	0	0	0	7.00	
8.00	Prepaid expenses	6,402,000	0	0	0	8.00	
9.00	Other current assets	99,000,000	0	0	0	9.00	
10.00	Due from other funds	57,709,000	0	0	0	10.00	
11.00	Total current assets (sum of lines 1-10)	241,300,000	0	0	0	11.00	
FIXED ASSETS							
12.00	Land	0	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	639,748,004	0	0	0	15.00	
16.00	Accumulated depreciation	-244,608,004	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	0	0	0	0	23.00	
24.00	Accumulated depreciation	0	0	0	0	24.00	
25.00	Minor equipment depreciable	0	0	0	0	25.00	
26.00	Accumulated depreciation	0	0	0	0	26.00	
27.00	HIT designated Assets	0	0	0	0	27.00	
28.00	Accumulated depreciation	0	0	0	0	28.00	
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00	
30.00	Total fixed assets (sum of lines 12-29)	395,140,000	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	303,550,000	0	0	0	34.00	
35.00	Total other assets (sum of lines 31-34)	303,550,000	0	0	0	35.00	
36.00	Total assets (sum of lines 11, 30, and 35)	939,990,000	0	0	0	36.00	
CURRENT LIABILITIES							
37.00	Accounts payable	48,035,000	0	0	0	37.00	
38.00	Salaries, wages, and fees payable	26,453,000	0	0	0	38.00	
39.00	Payroll taxes payable	0	0	0	0	39.00	
40.00	Notes and loans payable (short term)	8,305,000	0	0	0	40.00	
41.00	Deferred income	0	0	0	0	41.00	
42.00	Accelerated payments	96,954,000	0	0	0	42.00	
43.00	Due to other funds	0	0	0	0	43.00	
44.00	Other current liabilities	7,232,000	0	0	0	44.00	
45.00	Total current liabilities (sum of lines 37 thru 44)	186,979,000	0	0	0	45.00	
LONG TERM LIABILITIES							
46.00	Mortgage payable	366,492,000	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	4,893,000	0	0	0	49.00	
50.00	Total long term liabilities (sum of lines 46 thru 49)	371,385,000	0	0	0	50.00	
51.00	Total liabilities (sum of lines 45 and 50)	558,364,000	0	0	0	51.00	
CAPITAL ACCOUNTS							
52.00	General fund balance	381,626,000				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)	381,626,000	0	0	0	59.00	
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	939,990,000	0	0	0	60.00	

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020

Worksheet G-1

Date/Time Prepared:
4/29/2021 3:44 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		328,128,000		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		51,982,553				2.00
3.00	Total (sum of line 1 and line 2)		380,110,553		0		3.00
4.00	INCREASE IN TEMPORARILY RESTRICTED A	0		0		0	4.00
5.00	NET ASSETS WITH DONOR RESTRICTIONS	1,186,000		0		0	5.00
6.00	INCREASE UNRESTRICTED ASSETS	0		0		0	6.00
7.00	NET ASSETS RELEASED FROM RESTRICTION	330,000		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		1,516,000		0		10.00
11.00	Subtotal (line 3 plus line 10)		381,626,553		0		11.00
12.00	ROUNDING	553		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		553		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		381,626,000		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	INCREASE IN TEMPORARILY RESTRICTED A		0				4.00
5.00	NET ASSETS WITH DONOR RESTRICTIONS		0				5.00
6.00	INCREASE UNRESTRICTED ASSETS		0				6.00
7.00	NET ASSETS RELEASED FROM RESTRICTION		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	ROUNDING		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
4/29/2021 3:44 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	72,627,216		72,627,216	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	21,155,838		21,155,838	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	93,783,054		93,783,054	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	24,376,986		24,376,986	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT	0		0	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)	24,376,986		24,376,986	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	118,160,040		118,160,040	17.00
18.00	Ancillary services	415,031,931	555,563,624	970,595,555	18.00
19.00	Outpatient services	41,224,025	106,177,716	147,401,741	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		5,768,567	5,768,567	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC		0	0	24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NURSERY	10,137,507	0	10,137,507	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. line 1)	667,553,503	667,509,907	1,252,063,410	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		398,747,652		29.00
30.00	ADD (SPECIFY)	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	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		398,747,652		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN:14-0213

Period:
From 10/01/2019
To 09/30/2020

Worksheet G-3

Date/Time Prepared:
4/29/2021 3:44 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,252,063,410	1.00
2.00	Less contractual allowances and discounts on patients' accounts	821,811,164	2.00
3.00	Net patient revenues (line 1 minus line 2)	430,252,246	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	398,747,652	4.00
5.00	Net income from service to patients (line 3 minus line 4)	31,504,594	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	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	0	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	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC - OTHER REVENUE	8,330,493	24.00
24.01	NON-OPERATING INCOME	22,331,290	24.01
24.02	OTHER (SPECIFY)	0	24.02
24.50	COVID-19 PHE Funding	25,564,695	24.50
25.00	Total other income (sum of lines 6-24)	56,226,478	25.00
26.00	Total (line 5 plus line 25)	87,731,072	26.00
27.00	BAD DEBTS	14,446,404	27.00
27.01	JOINT VENTURE RECLASS	22,228,580	27.01
27.02	REVENUE RECLASS	-926,468	27.02
27.03	ROUNDING	3	27.03
28.00	Total other expenses (sum of line 27 and subscripts)	35,748,519	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	51,982,553	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS					Provider CCN:14-0213 HHA CCN: 14-7452	Period: From 10/01/2019 To 09/30/2020	Worksheet H Date/Time Prepared: 4/29/2021 3:44 pm	
						Home Health Agency I	PPS	
		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Pur- chased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	747,780	0	0	19,181	53,922	820,883	5.00
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	0	0	72,364	0	77,615	149,979	6.00
7.00	Physical Therapy	0	0	34,688	330,552	0	365,240	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	2,255,140	0	0	0	3,170	2,258,310	10.00
11.00	Home Health Aide	47,409	0	7,862	0	690	55,961	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	3,050,329	0	114,914	349,733	135,397	3,650,373	24.00
		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	10,316	831,199	0	831,199			5.00
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	0	149,979	0	149,979			6.00
7.00	Physical Therapy	0	365,240	0	365,240			7.00
8.00	Occupational Therapy	0	0	0	0			8.00
9.00	Speech Pathology	0	0	0	0			9.00
10.00	Medical Social Services	0	2,258,310	0	2,258,310			10.00
11.00	Home Health Aide	0	55,961	0	55,961			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	10,316	3,660,689	0	3,660,689			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN:14-0213

Period:

Worksheet H-1

HHA CCN: 14-7452

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
4/29/2021 3:44 pmHome Health
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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
			Bldgs & Fixtures	Movable Equipment				
		0	1.00	2.00	3.00	4.00	4A.00	
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	831,199	0	0	0	0	831,199	5.00
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	149,979	0	0	0	0	149,979	6.00
7.00	Physical Therapy	365,240	0	0	0	0	365,240	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	2,258,310	0	0	0	0	2,258,310	10.00
11.00	Home Health Aide	55,961	0	0	0	0	55,961	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	3,660,689	0	0	0	0	3,660,689	24.00
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General	831,199						5.00
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	44,058	194,037					6.00
7.00	Physical Therapy	107,294	472,534					7.00
8.00	Occupational Therapy	0	0					8.00
9.00	Speech Pathology	0	0					9.00
10.00	Medical Social Services	663,408	2,921,718					10.00
11.00	Home Health Aide	16,439	72,400					11.00
12.00	Supplies (see instructions)	0	0					12.00
13.00	Drugs	0	0					13.00
14.00	DME	0	0					14.00
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing	0	0					17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00	Homemaker Service	0	0					22.00
23.00	All Others (specify)	0	0					23.00
23.50	Telemedicine	0	0					23.50
24.00	Total (sum of lines 1-23)		3,660,689					24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN:14-0213

Period:

Worksheet H-1

HHA CCN: 14-7452

From 10/01/2019
To 09/30/2020Part II
Date/Time Prepared:
4/29/2021 3:44 pmHome Health
Agency I

PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00	3.00	4.00	5A.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-831,199	2,829,490 5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	149,979	6.00
7.00	Physical Therapy	0	0	0	0	365,240	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	2,258,310	10.00
11.00	Home Health Aide	0	0	0	0	55,961	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-831,199	2,829,490 24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0	831,199	831,199 25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000	0.293763	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN:14-0213

Period:

Worksheet H-2

HHA CCN: 14-7452

From 10/01/2019

Part I

To 09/30/2020

Date/Time Prepared:

Home Health
Agency I

PPS

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			BLDG & FIXT	MVBLE EQUIP				
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0		1,087	882,067	883,154	240,075	1.00
2.00	Skilled Nursing Care	194,037	0	0	0	194,037	52,747	2.00
3.00	Physical Therapy	472,534	0	0	0	472,534	128,453	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	2,921,718	0	0	0	2,921,718	794,233	6.00
7.00	Home Health Aide	72,400	0	0	0	72,400	19,681	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	3,660,689	0	1,087	882,067	4,543,843	1,235,189	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to decimal places.	6				0.000000		21.00
Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	0	0	0	0	0	294,333	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	294,333	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to decimal places.	6						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN:14-0213

Period:

Worksheet H-2

HHA CCN: 14-7452

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
4/29/2021 3:44 pmHome Health
Agency I

PPS

Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	
		14.00	15.00	16.00	17.00	23.00	24.00	
1.00	Administrative and General	0	0	0	0	0	1,417,562	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	246,784	2.00
3.00	Physical Therapy	0	0	0	0	0	600,987	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	3,715,951	6.00
7.00	Home Health Aide	0	0	0	0	0	92,081	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	6,073,365	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		25.00	26.00	27.00	28.00			
1.00	Administrative and General	0	1,417,562					1.00
2.00	Skilled Nursing Care	0	246,784	75,139	321,923			2.00
3.00	Physical Therapy	0	600,987	182,984	783,971			3.00
4.00	Occupational Therapy	0	0	0	0			4.00
5.00	Speech Pathology	0	0	0	0			5.00
6.00	Medical Social Services	0	3,715,951	1,131,403	4,847,354			6.00
7.00	Home Health Aide	0	92,081	28,036	120,117			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
19.50	Telemedicine	0	0	0	0			19.50
20.00	Total (sum of lines 1-19) (2)	0	6,073,365	1,417,562	6,073,365			20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.304472				21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS				Provider CCN:14-0213 HHA CCN: 14-7452		Period: From 10/01/2019 To 09/30/2020		Worksheet H-2 Part II Date/Time Prepared: 4/29/2021 3:44 pm	
						Home Health Agency I		PPS	
Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)		
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)						
		1.00	2.00						
1.00	Administrative and General	0	1,069	3,050,330	0	883,154	0	1.00	
2.00	Skilled Nursing Care	0	0	0	0	194,037	0	2.00	
3.00	Physical Therapy	0	0	0	0	472,534	0	3.00	
4.00	Occupational Therapy	0	0	0	0	0	0	4.00	
5.00	Speech Pathology	0	0	0	0	0	0	5.00	
6.00	Medical Social Services	0	0	0	0	2,921,718	0	6.00	
7.00	Home Health Aide	0	0	0	0	72,400	0	7.00	
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00	
9.00	Drugs	0	0	0	0	0	0	9.00	
10.00	DME	0	0	0	0	0	0	10.00	
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00	Clinic	0	0	0	0	0	0	14.00	
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00	Day Care Program	0	0	0	0	0	0	16.00	
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00	Homemaker Service	0	0	0	0	0	0	18.00	
19.00	All Others (specify)	0	0	0	0	0	0	19.00	
19.50	Telemedicine	0	0	0	0	0	0	19.50	
20.00	Total (sum of lines 1-19)	0	1,069	3,050,330		4,543,843	0	20.00	
21.00	Total cost to be allocated	0	1,087	882,067		1,235,189	0	21.00	
22.00	Unit cost multiplier	0.000000	1.016838	0.289171		0.271838	0.000000	22.00	
Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)		
		8.00	9.00	10.00	11.00	13.00	14.00		
1.00	Administrative and General	0	0	0	0	68,686	0	1.00	
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00	
3.00	Physical Therapy	0	0	0	0	0	0	3.00	
4.00	Occupational Therapy	0	0	0	0	0	0	4.00	
5.00	Speech Pathology	0	0	0	0	0	0	5.00	
6.00	Medical Social Services	0	0	0	0	0	0	6.00	
7.00	Home Health Aide	0	0	0	0	0	0	7.00	
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00	
9.00	Drugs	0	0	0	0	0	0	9.00	
10.00	DME	0	0	0	0	0	0	10.00	
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00	Clinic	0	0	0	0	0	0	14.00	
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00	Day Care Program	0	0	0	0	0	0	16.00	
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00	Homemaker Service	0	0	0	0	0	0	18.00	
19.00	All Others (specify)	0	0	0	0	0	0	19.00	
19.50	Telemedicine	0	0	0	0	0	0	19.50	
20.00	Total (sum of lines 1-19)	0	0	0	0	68,686	0	20.00	
21.00	Total cost to be allocated	0	0	0	0	294,333	0	21.00	
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	4.285196	0.000000	22.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS		Provider CCN:14-0213	Period: From 10/01/2019 To 09/30/2020	Worksheet H-2 Part II Date/Time Prepared: 4/29/2021 3:44 pm
		HHA CCN: 14-7452		
			Home Health Agency I	PPS

Cost Center Description		PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	PARAMED ED PRGM (ASSIGNED TIME)		
		15.00	16.00	17.00	23.00		
1.00	Administrative and General	0	0	0	0		1.00
2.00	Skilled Nursing Care	0	0	0	0		2.00
3.00	Physical Therapy	0	0	0	0		3.00
4.00	Occupational Therapy	0	0	0	0		4.00
5.00	Speech Pathology	0	0	0	0		5.00
6.00	Medical Social Services	0	0	0	0		6.00
7.00	Home Health Aide	0	0	0	0		7.00
8.00	Supplies (see instructions)	0	0	0	0		8.00
9.00	Drugs	0	0	0	0		9.00
10.00	DME	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0		13.00
14.00	Clinic	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0		19.00
19.50	Telemedicine	0	0	0	0		19.50
20.00	Total (sum of lines 1-19)	0	0	0	0		20.00
21.00	Total cost to be allocated	0	0	0	0		21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN:14-0213

Period:

Worksheet H-3

HHA CCN: 14-7452

From 10/01/2019

Part I

To 09/30/2020

Date/Time Prepared:

				Title XVIII		Home Health Agency I		PPS	
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)		
		0	1.00	2.00	3.00	4.00	5.00		
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
	Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	321,923		321,923	12,909	24.94	1.00	
2.00	Physical Therapy	3.00	783,971	421,853	1,205,824	8,058	149.64	2.00	
3.00	Occupational Therapy	4.00	0	209,333	209,333	3,361	62.28	3.00	
4.00	Speech Pathology	5.00	0	0	0	492	0.00	4.00	
5.00	Medical Social Services	6.00	4,847,354		4,847,354	62	78,183.13	5.00	
6.00	Home Health Aide	7.00	120,117		120,117	1,468	81.82	6.00	
7.00	Total (sum of lines 1-6)		6,073,365	631,186	6,704,551	26,350		7.00	
Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Program Visits				
					Part B				
					Not Subject to Deductibles & Coinsurance	Subject to Deductibles			
		0	1.00	2.00	3.00	4.00	5.00		
	Limitation Cost Computation								
8.00	Skilled Nursing Care		16974	0	5,727			8.00	
9.00	Physical Therapy		16974	0	3,981			9.00	
10.00	Occupational Therapy		16974	0	1,652			10.00	
11.00	Speech Pathology		16974	0	195			11.00	
12.00	Medical Social Services		16974	0	31			12.00	
13.00	Home Health Aide		16974	0	615			13.00	
14.00	Total (sum of lines 8-13)			0	12,201			14.00	
Cost Center Description		From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)		
		0	1.00	2.00	3.00	4.00	5.00		
	Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	0	11,038	11,038	21,692	0.508851	15.00	
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00	
Cost Center Description		Program Visits			Cost of Services				
		Part A	Part B						
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
								6.00	7.00
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
	Cost Per Visit Computation								
1.00	Skilled Nursing Care	0	5,727		0	142,831		1.00	
2.00	Physical Therapy	0	3,981		0	595,717		2.00	
3.00	Occupational Therapy	0	1,652		0	102,887		3.00	
4.00	Speech Pathology	0	195		0	0		4.00	
5.00	Medical Social Services	0	31		0	2,423,677		5.00	
6.00	Home Health Aide	0	615		0	50,319		6.00	
7.00	Total (sum of lines 1-6)	0	12,201		0	3,315,431		7.00	
Cost Center Description									
		6.00	7.00	8.00	9.00	10.00	11.00		
	Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00	
9.00	Physical Therapy							9.00	
10.00	Occupational Therapy							10.00	
11.00	Speech Pathology							11.00	
12.00	Medical Social Services							12.00	
13.00	Home Health Aide							13.00	
14.00	Total (sum of lines 8-13)							14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN:14-0213

Period:

Worksheet H-3

HHA CCN: 14-7452

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
4/29/2021 3:44 pm

Title XVIII

Home Health
Agency I

PPS

Cost Center Description		Program Covered Charges			Cost of Services	Agency 1		
		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
			6.00	7.00		8.00	9.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00
Cost Center Description		Total Program Cost (sum of cols. 9-10)						
		12.00						
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	142,831						1.00
2.00	Physical Therapy	595,717						2.00
3.00	Occupational Therapy	102,887						3.00
4.00	Speech Pathology	0						4.00
5.00	Medical Social Services	2,423,677						5.00
6.00	Home Health Aide	50,319						6.00
7.00	Total (sum of lines 1-6)	3,315,431						7.00
Cost Center Description								
		12.00						
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN:14-0213

Period:

Worksheet H-3

HHA CCN: 14-7452

From 10/01/2019
To 09/30/2020Part II
Date/Time Prepared:
4/29/2021 3:44 pm

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.239951	1,758,079	421,853	col. 2, line 2.00	1.00
2.00	Occupational Therapy	67.00	0.294777	710,141	209,333	col. 2, line 3.00	2.00
3.00	Speech Pathology	68.00	0.000000	97,777	0	col. 2, line 4.00	3.00
4.00	Cost of Medical Supplies	71.00	0.508836	21,692	11,038	col. 2, line 15.00	4.00
5.00	Cost of Drugs	73.00	0.343809	0	0	col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN:14-0213 HHA CCN: 14-7452	Period: From 10/01/2019 To 09/30/2020	Worksheet H-4 Part I-II Date/Time Prepared: 4/29/2021 3:44 pm
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	2,225,057
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	138,862
13.00	Total PPS Reimbursement - LUPA Episodes		0	41,909
14.00	Total PPS Reimbursement - PEP Episodes		0	25,860
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	21,035
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	203
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	2,452,926
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	2,452,926
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	2,452,926
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	2,452,926
30.00	MISC ADJUSTMENT		0	-3,406
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
30.99	Demonstration payment adjustment amount before sequestration		0	0
31.00	Subtotal (see instructions)		0	2,449,520
31.01	Sequestration adjustment (see instructions)		0	35,896
31.02	Demonstration payment adjustment amount after sequestration		0	0
32.00	Interim payments (see instructions)		0	2,413,624
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED PROGRAM BENEFICIARIES		Provider CCN:14-0213 HHA CCN: 14-7452		Period: From 10/01/2019 To 09/30/2020		Worksheet H-5 Date/Time Prepared: 4/29/2021 3:44 pm	
				Home Health Agency I		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		0		2,413,624	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		0		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			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			0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		2,413,624	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			0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50			0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		0		2,413,624	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF CAPITAL PAYMENT		Provider CCN:14-0213	Period: From 10/01/2019 To 09/30/2020	Worksheet L Parts I-III Date/Time Prepared: 4/29/2021 3:44 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		5,213,211	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		97,339	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		196.66	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		2.07	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		15.01	8.00
9.00	Sum of lines 7 and 8		17.08	9.00
10.00	Allowable disproportionate share percentage (see instructions)		3.52	10.00
11.00	Disproportionate share adjustment (see instructions)		183,505	11.00
12.00	Total prospective capital payments (see instructions)		5,494,055	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00